

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

BP

01802

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01752

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Parkville</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>8009 Harris Ave.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Parkville</b> d. STREET ADDRESS <b>8009 Harris Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>A.M. Katherine Adams</b> First Middle Last		4. DATE OF DEATH <b>February 9, 1966</b> Month Day Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 11, 1880</b>
9. AGE (In years last birthday) <b>85</b> yrs.		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Julius Berger</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Schmidt</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Julius F. Adams</b>		Address <b>8009 Harris Ave. 21234</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerosis (C.V. disease)</b> 4221 DUE TO (b) <b>Generalized arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Jan. 1946</b> to <b>2/9, 1966</b> that (I) (we) last saw the deceased alive on <b>2/8, 1966</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Conrad L. Richter</b>		22b. DATE SIGNED <b>2/11/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Conrad L. Richter, M.D.</b>		22d. ADDRESS <b>3128 Harford Road</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>2/12/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial Park</b>	23d. LOCATION (City, town or county) (State) <b>Parkville, Md.</b>
24. FUNERAL DIRECTOR <b>Ullrich Funeral Home</b>		25a. REC'D BY REGISTRAR <b>FEB 16 1966</b>	
ADDRESS <b>4210 Belair Road.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

01553

01553

1955

*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page]*

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any information is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

00

03

2

BP 2

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>RANDALLSTOWN</b>		c. LENGTH OF STAY IN 1b <b>8700 Block Liberty Road</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>8700 Block Liberty Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		f. STREET ADDRESS <b>1123 Hollen Road</b>		g. 21212		h. 2	
3. NAME OF DECEASED (Type or print) <b>WALTER SCOTT ALLEN III</b>		4. DATE OF DEATH <b>2 13 19 66</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>Jan. 19, 1933</b>		9. AGE (In years last birthday) <b>33</b> yrs.		10. IF UNDER 1 YEAR Months <b>2</b> Days <b>13</b>		11. IF UNDER 24 HRS. Hours <b>19</b> Min. <b>66</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance Technician-</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Totalizator Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Walter S. Allen, Jr.</b>	
14. MOTHER'S MAIDEN NAME <b>Anna</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>Marie C. Allen</b>		17. INFORMANT <b>same</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple traumatic injuries</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>8129</b> (c) <b>8129</b> DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>8129</b>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Body found along side of road in 8700 block of Liberty Road</b> <b>Thought to be victim of hit and run driver</b>		20c. TIME OF INJURY Month, Day, Year <b>2-13 19 66</b> Hour <b>6:55</b> a.m. <b>FOUND:</b> ? p.m.		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>		20f. (City or town) <b>Randallstown</b>		(County) <b>Balto.</b>		(State) <b>Md.</b>		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
22. ACTUAL SIGNATURE <b>RUSSELL S. FISHER, M.D.</b>		23. EXAMINER'S NAME (Type) <b>RUSSELL S. FISHER, M.D.</b>		24. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		25. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		26. DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
27. ADDRESS (Street, city, town, or county) <b>Baltimore, Md.</b>		28. DATE SIGNED <b>2-14-66</b>		29. DATE <b>FEB 16 1966</b>		30. REC'D BY REGISTRAR <b>Charles Judge</b>		31. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
32. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		33. DATE THEREOF <b>2-17-66</b>		34. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cem.</b>		35. LOCATION (City, town, or country) <b>Baltimore, Md.</b>		36. (State) <b>Md.</b>	
37. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc Baltimore, Md.</b>		38. ADDRESS <b>Baltimore, Md.</b>		39. DATE <b>FEB 16 1966</b>		40. REC'D BY REGISTRAR <b>Charles Judge</b>		41. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

01123

01802

1917-18

*[Handwritten signature]*

1917-18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

01804		01754	
1. PLACE OF DEATH a. COUNTY <u>Balto</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodstock</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodstock</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Summithe Route 1 Box 168</u>		d. STREET ADDRESS <u>Summithe Route 1 Box 168</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>S.</u> Last <u>Antkowiak</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>3</u> Year <u>1966</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <u>Dec. 12, 1911</u>
9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Analyst</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Air Craft</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Walter Antkowiak</u>		14. MOTHER'S MAIDEN NAME <u>Rose Black</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>		16. SOCIAL SECURITY NO. <u>219-10-34687</u>	
17. INFORMANT <u>Wm. C. Antkowiak</u>		Address <u>Woodstock</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY INFARCTION</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary insufficiency</u> DUE TO (c) <u>A.S.C.V.D.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</u> <u>10 yrs.</u> <u>10 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>MAR</u> , 19 <u>66</u> to <u>2-3</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2-3</u> , 19 <u>66</u> , and that death occurred at <u>5:30</u> M. from the causes and on the date stated above.			
22a. SIGNATURE <u>R.V. Houck, Jr.</u>		22b. DATE SIGNED <u>  </u>	
22c. PHYSICIAN'S NAME (Type) <u>R.V. Houck, Jr.</u>		22d. ADDRESS <u>SYKESVILLE MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-7-1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Lake View Memorial</u>		23d. LOCATION (City, town or county) (State) <u>Md.</u>	
24. FUNERAL DIRECTOR <u>Loring Byrnes</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. DATE <u>FEB 7 1966</u>	

LEV

1970

ADSR

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
01805				CERTIFICATE OF DEATH				01755					
1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Baltimore</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>				c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTO RURAL</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>TOWSON NURSING HOME</u>				d. STREET ADDRESS <u>Box 123 Manor Rd</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>LOUISE SOPHIA ARNESS</u>				4. DATE OF DEATH <u>2/7/66</u>				5. AGE (In years last birthday) <u>97</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.					
6. SEX <u>F</u>		7. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/9/68</u>		9. AGE (In years last birthday) <u>97</u> yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <u>Chicago</u>					
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Wm. Bell</u>				14. MOTHER'S MAIDEN NAME <u>LOUISE Steindorf</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <u>—</u>				17. INFORMANT <u>Son.</u> Address <u>SAME</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerosis</u> DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 10</u> , 19 <u>65</u> , to <u>Feb 7</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Feb 7</u> , 19 <u>66</u> , and that death occurred at <u>2:20</u> PM, from the causes and on the date stated above.													
22a. SIGNATURE <u>Laurence C. Post</u>				22b. DATE SIGNED <u>2/8/66</u>				22c. PHYSICIAN'S NAME (Type) <u>LAURENCE C. Post</u>					
22d. ADDRESS <u>6805 York Rd. - Baltimore 12 Ma</u>				22e. MED. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22f. ADDRESS <u>6805 York Rd. - Baltimore 12 Ma</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>				23b. DATE THEREOF <u>2/9/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greenmount</u>		23d. LOCATION (City, town or county) (State) <u>BALTO</u>					
24. FUNERAL DIRECTOR <u>Ed. Germany</u>				25a. REC'D BY REGISTRAR <u>B</u> DATE <u>10 1966</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

01252

01252

*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page. The text is mirrored and difficult to decipher.]*

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please supply carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

01806		01756	
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>St. Joseph Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before/admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>21206</u> d. STREET ADDRESS <u>4208 Arizona Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Homer</u> Middle <u>R.</u> Last <u>Baer</u>		4. DATE OF DEATH Month <u>February</u> Day <u>11</u> Year <u>1966</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 16, 1900</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Office Mgr.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Samuel Hutman</u>	9. AGE (in years last birthday) <u>65</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>11</u> Days <u>19</u> Hours <u>66</u> Min.
11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John A. Baer</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Ross</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>same</u>	
17. INFORMANT <u>Mrs Valeria M. Baer</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction secondary to right coronary occlusion.</u> 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>4201</u> DUE TO (c) <u>4201</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Perforated duodenal ulcer; Cirrhosis of liver, severe.</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 9</u> , 19 <u>66</u> , to <u>Feb. 11</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Feb. 11</u> , 19 <u>66</u> , and that death occurred at <u>5:45 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>William L. Wilkie</u>		22b. DATE SIGNED <u>2/12/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>William L. Wilkie, M.D.</u>		22d. ADDRESS <u>7620 York Rd. Baltimore, Md. 21204</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE THEREOF <u>2-16-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Meyersdale, Penna.</u>
24. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc. Baltimore, Md.</u>		25a. REC'D BY REGISTRAR <u>FEB 15 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

10510

10510

10

10

10510

10510

10

10510

10510

10510

10510

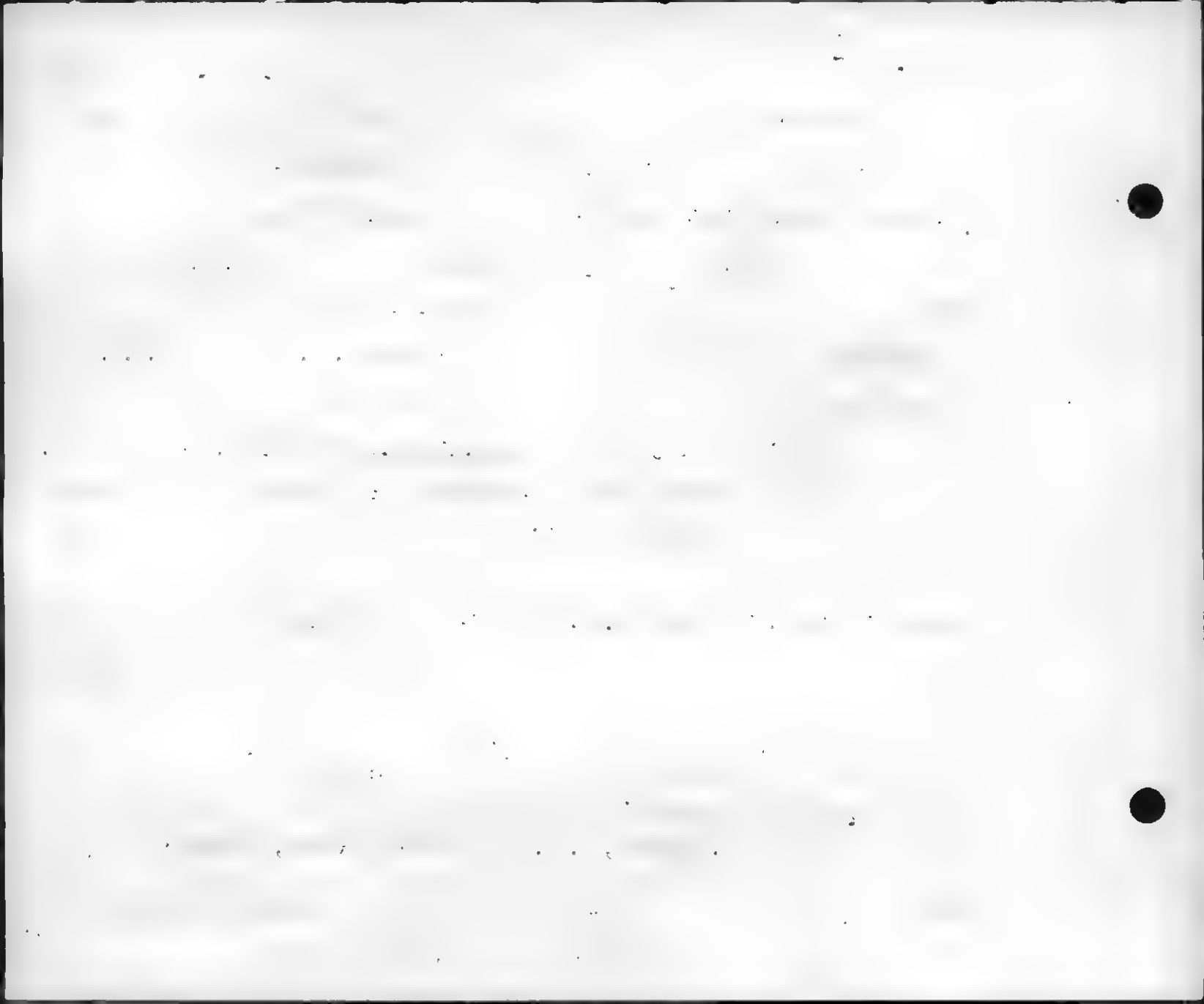
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>20 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. STREET ADDRESS <b>343 STILLWATER ROAD</b>	
3. NAME OF DECEASED (Type or print) First <b>STEVEN</b> Middle <b>BALINT</b> Last <b>BALINT</b>		4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>8</b> Year <b>1966</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JANUARY 23, 1916</b>
9. AGE (in years last birthday) <b>50 yrs.</b>		IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ELECTRICIAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>VA Hospital</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>NEW YORK, N. Y.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN BALINT</b>		14. MOTHER'S MAIDEN NAME <b>HELEN URBAN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>173 07 7665</b>	
17. INFORMANT <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION LEFT VENTRICLE</b> DUE TO (b) <b>CORONARY OCCLUSION</b> DUE TO (c) <b>BRONCHOPNEUMONIA, PULMONARY EDEMA. PASSIVE VENOUS CONGESTION VISCERA</b>		INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b> <b>RECENT</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <del>he</del> (this hospital) attended the deceased from <b>1/19/66</b> , 19__ to <b>2/8/66</b> , 19__, that <del>he</del> (we) last saw the deceased alive on <b>2/8/66</b> , 19__, and that death occurred at <b>8:15 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <i>William B. Kingree</i>		22b. DATE SIGNED <b>2/8/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>WILLIAM B. KINGREE, M. D.</b>		22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>2/11/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>		23d. LOCATION (City, town or county) (State) <b>BALTIMORE, MARYLAND</b>	
24. FUNERAL DIRECTOR <i>James E. Bruzdinski</i>		25a. REC'D BY REGISTRAR <b>Bruzdinski Funeral Home</b>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		25c. ADDRESS <b>1407 Eastern Avenue, Baltimore, Md.</b>	

FEB 11 1966



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

01808

Item #2 Film #4373 3/11/66 pc

01758

1. PLACE OF DEATH e. COUNTY <u>BALTO.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>6307 FREDERICK RD</u>		d. STREET ADDRESS <u>6307 FREDERICK RD</u>	
3. NAME OF DECEASED (Type or print) <u>ANNIE M. BANTZ</u>		4. DATE OF DEATH Month <u>FEB</u> Day <u>9</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/12/79</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MD</u>	
11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>JOHN W. HORNER</u>		14. MOTHER'S MAIDEN NAME <u>MAY A. BOWERS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>HENRY H. BANTZ JR.</u>	
17. INFORMANT <u>HENRY H. BANTZ JR.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral arteriosclerosis</u> <u>ASCD</u> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from <u>11/1</u> , 19 <u>65</u> to <u>2/9</u> , 19 <u>66</u> , that (I) ( <del>we</del> ) last saw the deceased alive on <u>12/15</u> , 19 <u>65</u> , and that death occurred at <u>9:50 PM</u> , from the causes and on the date stated above			
22a. SIGNATURE <u>J J NOLAN</u>		22b. DATE SIGNED <u>2/10/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>J J NOLAN</u>		22d. ADDRESS <u>Baltimore Maryland 71229</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>2/5/65</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LOUDON PARK</u>	23d. LOCATION (City, town or county) (State) <u>BALTO. MD.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>F. S. MACNABB</u>		25a. REC'D BY REGISTRAR <u>21228</u>	
25b. REGISTRAR'S SIGNATURE <u>J. J. MacNabb</u>		DATE <u>FEB 14 1966</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

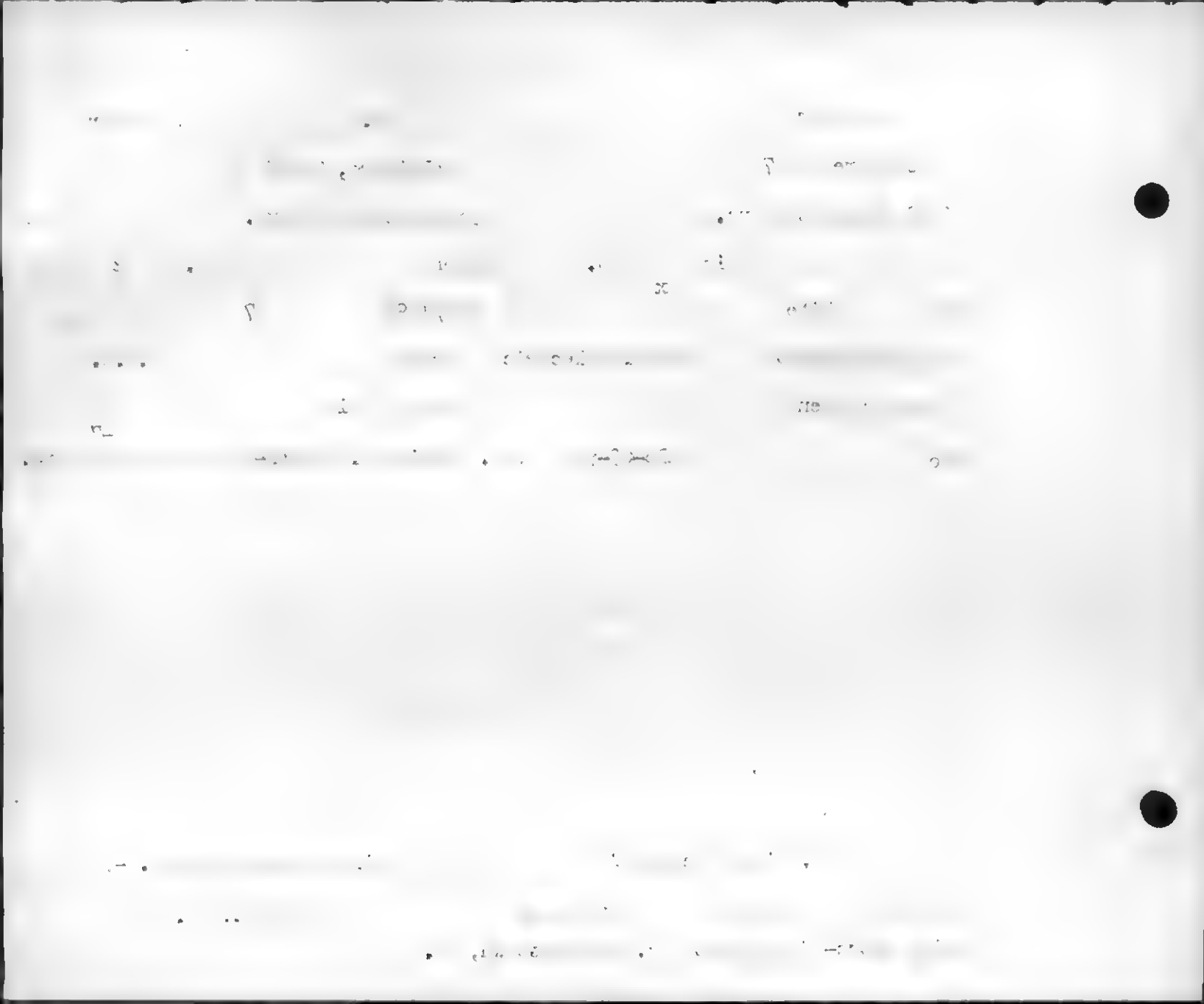
01809

Items #3 & 4 and 1111 #4373 2/17/66 DC

01759

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore 21207</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>3511 Washington Ave.</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore, 21207</b> d. STREET ADDRESS <b>3511 Washington Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Paris</b> <b>Parrie</b> <b>C.</b> <b>Barden</b> First Middle Last				4. DATE OF DEATH <b>Feb.</b> <b>12</b> <b>19</b> <b>66</b> Month Day Year			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9/1/1898</b> 9. AGE (in years last birthday) <b>67</b> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Superintendent</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>Western Electric</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas Barden</b>				14. MOTHER'S MAIDEN NAME <b>Martha Davis</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <b>216-03-9598</b>		17. INFORMANT <b>Mrs. Bernice M. Barden-3511 Washington Ave.</b> Address <b>-7</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> DUE TO (b) <b>Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1/10</b> , 19 <b>66</b> , to <b>2/10</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Milton Schlenoff</b>				22b. DATE SIGNED <b>2/10</b>		22c. PHYSICIAN'S NAME (Type) <b>Dr. Milton Schlenoff</b>	
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>2/15/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>	
24. FUNERAL DIRECTOR <b>Loring Byers-8728 Liberty Rd. Randallstown, Md.</b>				25a. REC'D BY REGISTRAR <b>FEB 16 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. H. Judge</b>	

MEDICAL CERTIFICATION



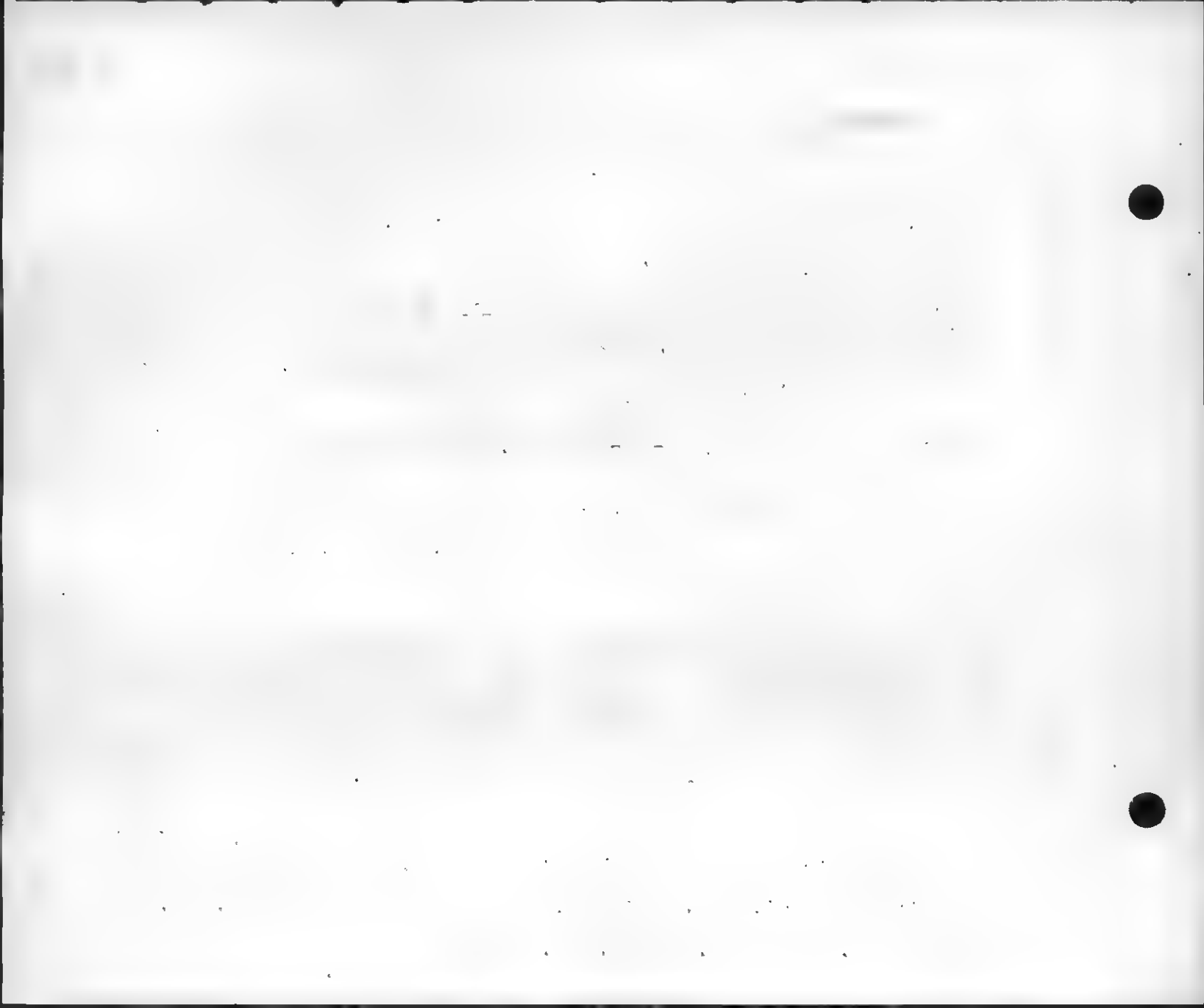
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>TOWSON</u> <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore, Maryland</u>	
c. LENGTH OF STAY IN ID <u>9 days</u>		d. STREET ADDRESS <u>2831 Chesterfield Ave.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>St. Joseph Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Theresa M. Barry</u>		4. DATE OF DEATH <u>2 6 22</u> 19 <u>66</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-4-1898</u>
9. AGE (in years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR: Months <u>6</u> Days <u>22</u> Hours <u>19</u> Min.	
11. BIRTHPLACE (County & State, or foreign country) <u>Balto., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Spence</u>		14. MOTHER'S MAIDEN NAME <u>Marguerite ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-01-5775</u>	
17. INFORMANT <u>Mr. George Barry</u>		Address <u>(Same)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Terminal Ca Of Omentum with Metastasis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a.m. p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2-13-66</u> , 19 <u>66</u> , to <u>2-22</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2-22</u> 19 <u>66</u> , and that death occurred at <u>1:10 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Dr. Tadalan</u>		22b. DATE SIGNED <u>2-22-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Leonardo Tadalan/ Nelson de la Paz</u>		22d. ADDRESS <u>St. Joseph Hospital</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2/25/66.</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Balto. Md.</u>
24. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc. Balto. Md. 21214</u>		25a. REC'D BY REGISTRAR <u>24 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

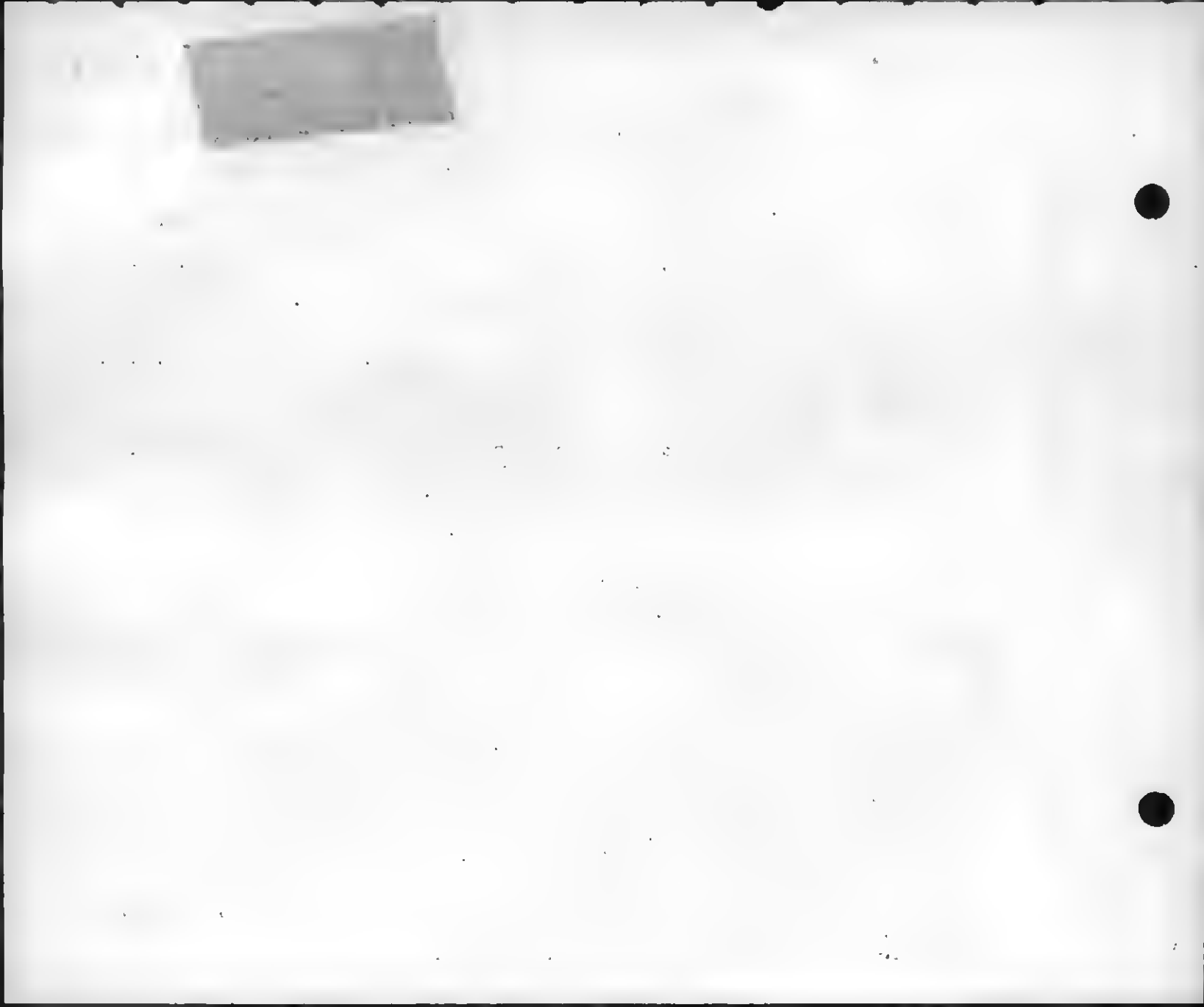


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>County</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>			c. LENGTH OF STAY IN ID <u>3 days</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Baltimore County Gen. Hosp.</u>					d. STREET ADDRESS <u>3706 Laburman Drive</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Clyde</u> Middle <u>A.</u> Last <u>Bastin</u>					4. DATE OF DEATH Month <u>Feb.</u> Day <u>15</u> Year <u>1966</u>					
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/25/1888</u>		9. AGE (in years last birthday) <u>77</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Structural Iron</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Peter Bastin</u>					14. MOTHER'S MAIDEN NAME <u>Marie</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>216-07-2896</u>		17. INFORMANT <u>Lucille Bowen 3706 Laburman Dr.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Pneumonia</u> <u>5271</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Congestive Heart Failure</u> DUE TO (c) <u>Emphysema</u>								INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 13</u> , 19 <u>66</u> to <u>Feb. 15</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Feb. 15</u> , 19 <u>66</u> , and that death occurred at <u>4:40</u> M. from the causes and on the date stated above.										
22a. SIGNATURE <u>L. B. Lerma</u>					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>2-15-66</u>			
22c. PHYSICIAN'S NAME (Type) <u>L. B. Lerma</u>					22d. ADDRESS <u>Baltimore County Gen. Hosp.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>2/19/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>			
24. FUNERAL DIRECTOR <u>Edsworth Arm</u>					ADDRESS <u>cost 4600 Liberty Heights Ave.</u>		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

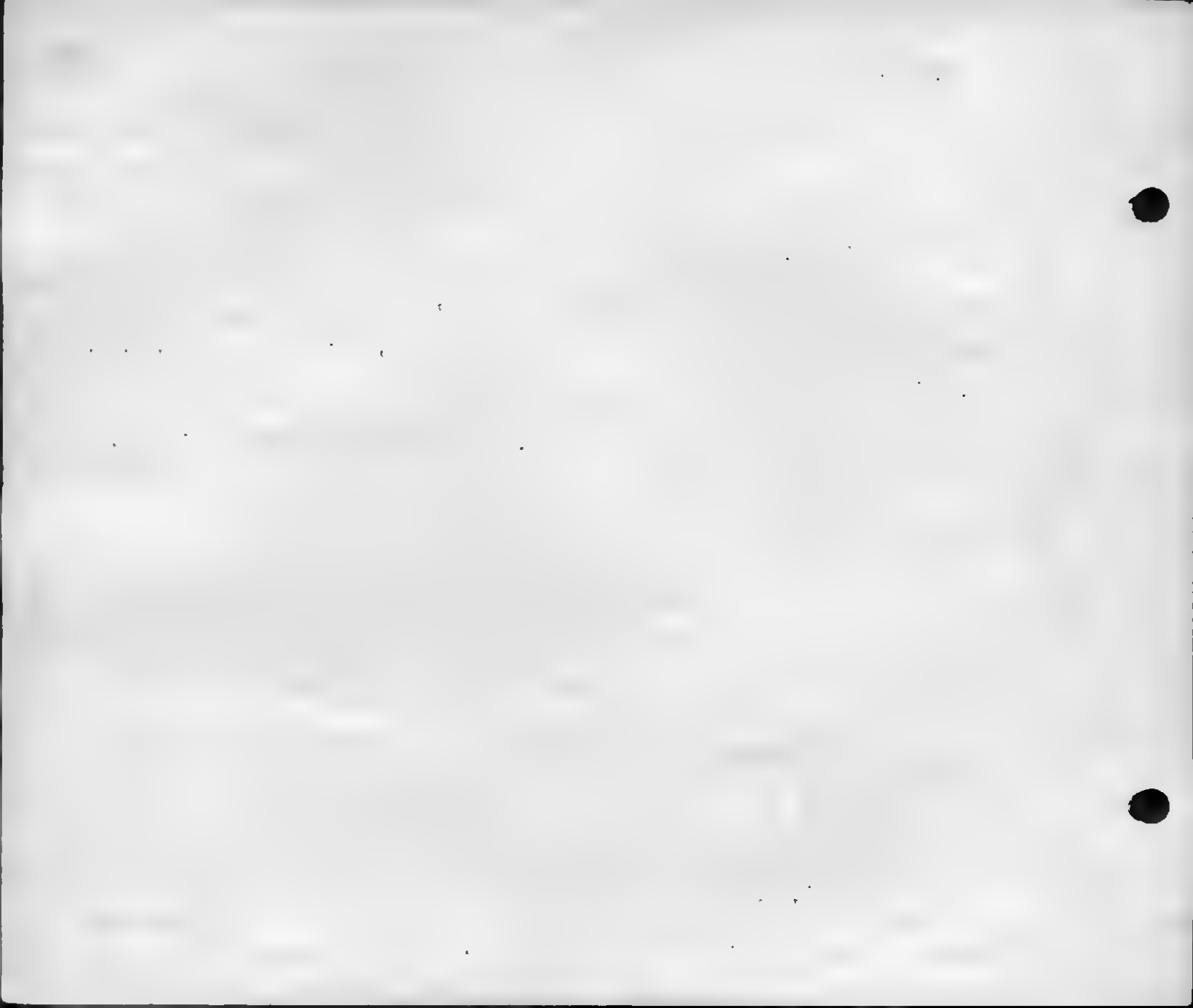
## CERTIFICATE OF DEATH

01812

01762

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>1806 Summit Avenue</b> c. LENGTH OF STAY IN TB <b>1</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>1806 Summit Avenue</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>1806 Summit Avenue</b> d. STREET ADDRESS <b>1806 Summit Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Elizabeth Bauersfeld</b>		4. DATE OF DEATH Month <b>February</b> Day <b>4</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>	8. DATE OF BIRTH <b>July 14, 1884</b>
9. AGE (in years last birthday) <b>81 yrs.</b>		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b>	11. IF UNDER 24 HRS Hours <b>1</b> Min. <b>1</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore, Maryland</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Mr. Weincl</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Mr. Paul Bauersfeld 7304 Martell Ave.</b>	
17. INFORMANT <b>Mr. Paul Bauersfeld 7304 Martell Ave.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Hypertension</b> (a), stating the underlying cause last. (c) <b>Arteriosclerotic Vascular Disease</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>June 1965</b> to <b>Feb 1966</b> , that (I) (we) last saw the deceased alive on <b>2/4</b> , 19 <b>66</b> , and that death occurred at <b>10</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>John G. Orish</b>		22b. DATE SIGNED <b>2/5/66</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <b>8019 Philadelphia Road</b>	
23a. BURIAL, CREMATION, REMEM. (Type)	23b. DATE THEREOF <b>Feb. 7, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Clarence Hoffmann Funeral Home 3218 Hudson St.</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 9 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>W. Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

### CERTIFICATE OF DEATH

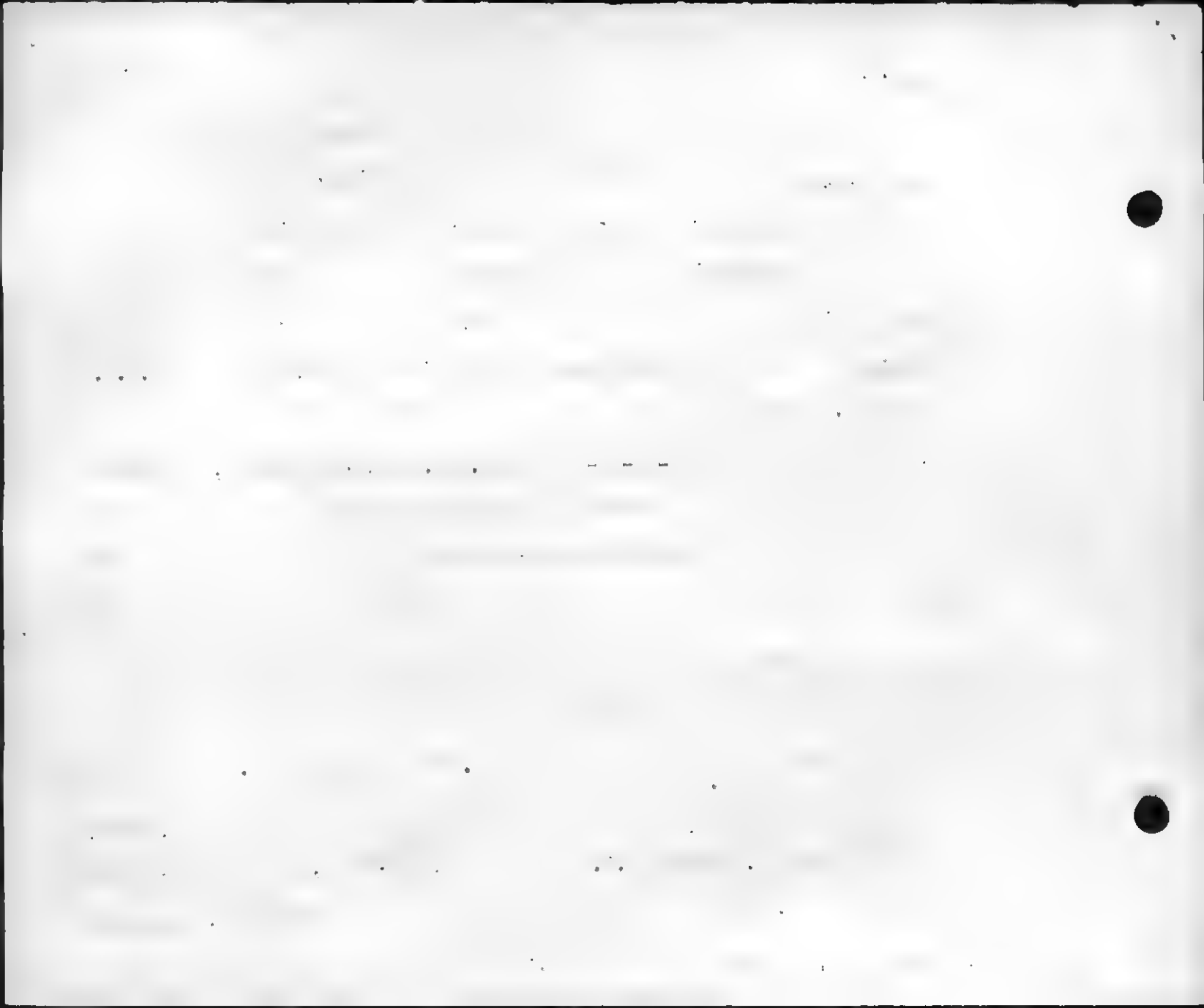
01813

01763

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN 1b <b>110 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>3913 Parkside Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <b>CHRISTIAN</b> Middle <b>David</b> Last <b>BAYNES</b>			<b>4. DATE OF DEATH</b> Month <b>FEBRUARY</b> Day <b>19</b> Year <b>1966</b>				
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>11/27/09</b>		<b>9. AGE</b> (in years last birthday) <b>56</b> yrs. IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HRS. _____		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Florist</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Florist (OWN)</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Baltimore, Maryland</b>			
<b>13. FATHER'S NAME</b> <b>Henry T. Baynes</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>Sophia Grieb</b>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW II</b>		<b>16. SOCIAL SECURITY NO.</b> <b>212-30-85-79</b>		<b>17. INFORMANT</b> Address <b>Clin. Rec. VAH, Fort Howard, Maryland</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL VASCULAR ACCIDENT</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CARCINOMA OF THE LARYNX</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>DAYS</b> <b>YEAR</b>		
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)				
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b> (County) (State)		<b>21. I certify that</b> <del>XX</del> (this hospital) attended the deceased from <b>Nov. 1st 1965</b> to <b>Feb. 19 1966</b> , that (I) (we) last saw the deceased alive on <b>Feb. 19 1966</b> , and that death occurred at <b>10:15 AM</b> , from the causes and on the date stated above.					
<b>22a. SIGNATURE</b> <i>[Signature]</i> <b>M.D.</b>					<b>225. DATE SIGNED</b> <b>2/19/66</b>		
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>LOUIS E. KIMMEL, M.D.</b>					<b>22d. ADDRESS</b> <b>VA HOSPITAL, FORT HOWARD, MARYLAND</b>		
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>2/23/66</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Baltimore National</b>			
<b>23d. LOCATION</b> (City, town or county) (State) <b>Baltimore, Maryland</b>		<b>25a. REC'D BY REGISTRAR</b> <b>25b. REGISTRAR'S SIGNATURE</b> <b>Schmunek Funeral Home</b> <b>3331 Brehms Lane</b> <b>Baltimore, Maryland</b> <b>FEB 23 1966</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

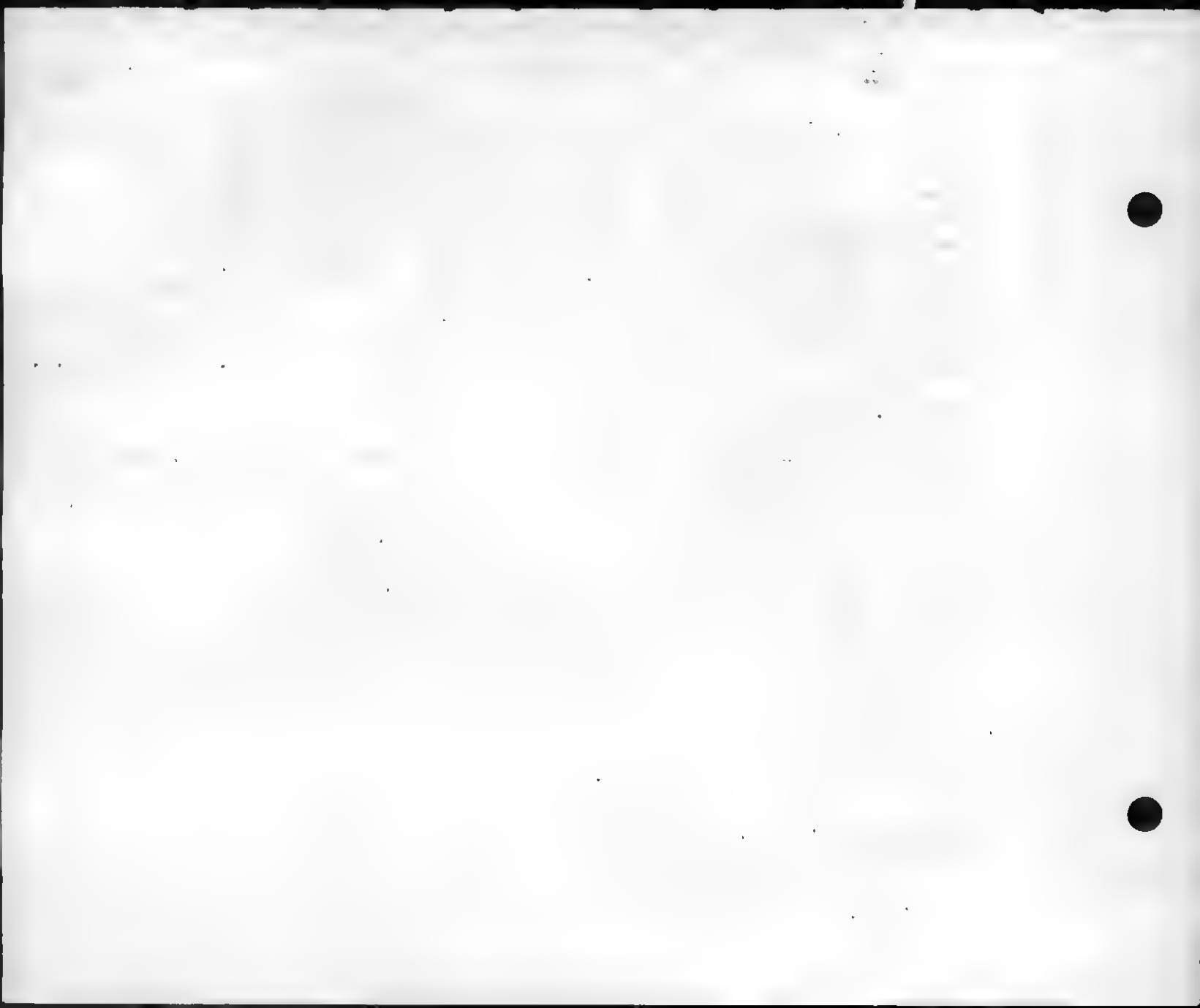


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

01814		01264	
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b> c. LENGTH OF STAY IN 1b <b>4 mo.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Rosewood State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> d. STREET ADDRESS <b>Route 2</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Myla</b> Middle <b>Gay</b> Last <b>BEAHN</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>6</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/14/54</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dependent</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	9. AGE (In years last birthday) <b>11</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (County & State, or foreign country) <b>Berkley Springs, W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Dale E. Beahn</b>		14. MOTHER'S MAIDEN NAME <b>Helen Bohrer</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Rosewood Records, Owings Mills, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SHOCK</b> DUE TO (b) <b>DEHYDRATION &amp; ELECTROLYTE IMBALANCE</b> DUE TO (c) <b>ENTERITIS (ETIOLOGY UNDETERMINED)</b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>6 hrs</b> <b>4 days</b> <b>6 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>MENTAL RETARDATION</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2/28</b> , 1965, to <b>2/6</b> , 1966, that (I) (we) last saw the deceased alive on <b>2/6</b> 1966, and that death occurred at <b>8:00</b> PM, from the causes and on the date stated above.			
22a. SIGNATURE <b>Harry M. Solomon</b>		22b. DATE SIGNED <b>2/6/66</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>FEB. 9, 66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR LAWN MEMORIAL</b>		23d. LOCATION (City, town or county) (State) <b>HAGERSTOWN MD.</b>	
24. FUNERAL DIRECTOR <b>Charles E. Thompson</b>		25a. REC'D BY REGISTRAR <b>FEB 10 1966</b>	
ADDRESS <b>Clear Spring, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

137

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore, 21224</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>St. Joseph Hospital</u>		e. STREET ADDRESS <u>735 S. Ponca St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Molly</u> Middle <u>Helen</u> Last <u>Bearman</u>		4. DATE OF DEATH Month <u>February</u> Day <u>22</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-22-1900</u>
9. AGE (in years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR IF FUNERAL 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Weber</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Ziegelhofer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>William V. Bearman</u>		Address <u>735 S. Ponca St. #24</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Embolism</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 29</u> , 19 <u>66</u> to <u>Feb. 22</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Feb. 22</u> , 19 <u>66</u> , and that death occurred at <u>6:15 PM</u> , from the causes and on the date stated above. 22a. SIGNATURE <u>T.J. Paglinauan</u> 22b. DATE SIGNED <u>Feb. 22 1966</u> 22c. PHYSICIAN'S NAME (Type) <u>T.J. Paglinauan</u> 22d. ADDRESS <u>7620 York Rd. Baltimore, Md. 21204</u> 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>2-26-66</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Baltimore County, Maryland</u> 24. FUNERAL DIRECTOR <u>Charles S. Geiler</u> 24a. ADDRESS <u>901 S. Conkling St. #24</u> 24b. REC'D BY REGISTRAR <u>FEB 25 1966</u> 24c. REGISTRAR'S SIGNATURE <u>Charles S. Geiler</u>			



FOR STATE  
HEALTH DEPT

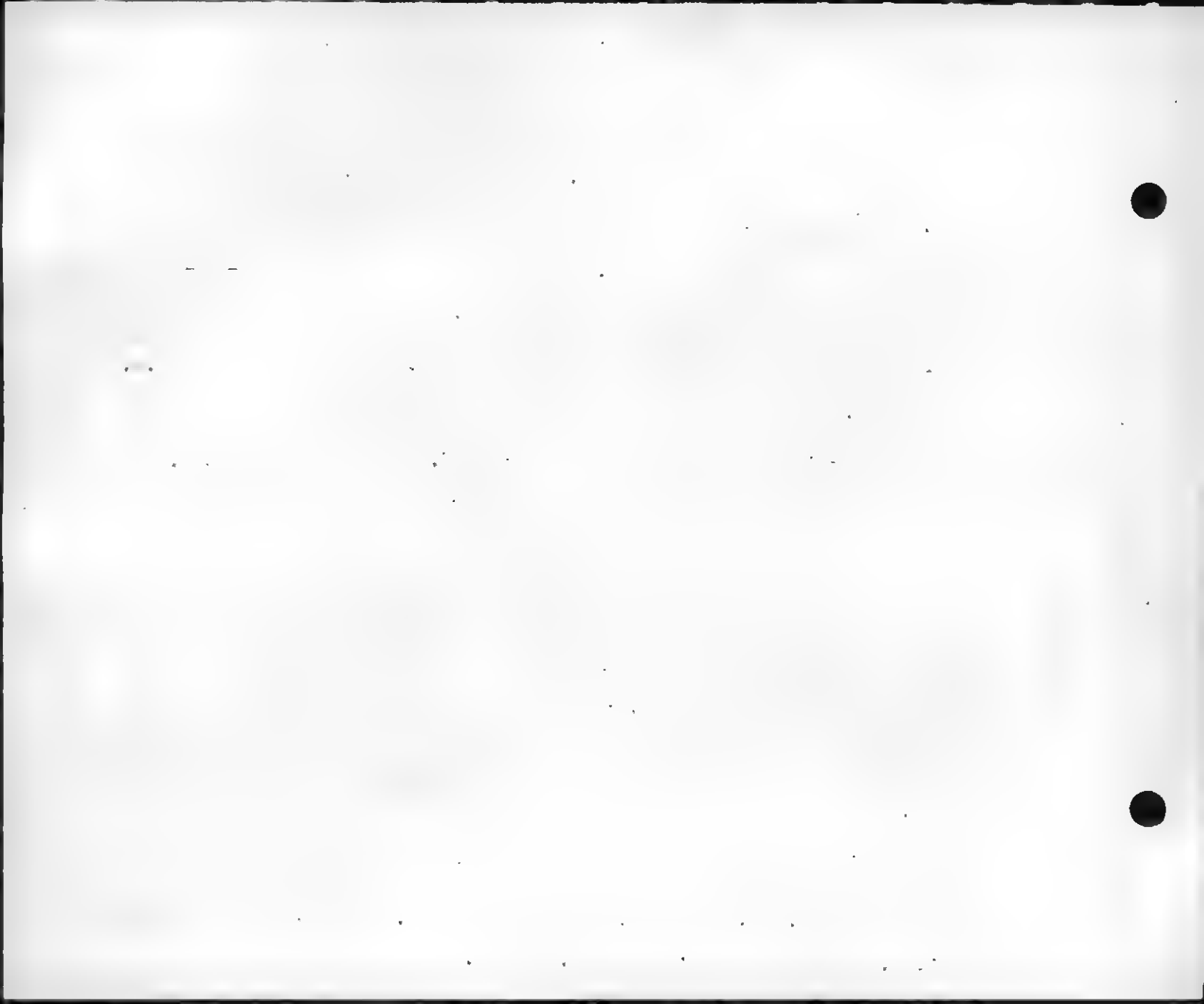
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01766

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sparrows Point</b> c. LENGTH OF STAY IN 1b <b>1 hr.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Plant Dispensary</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riviera Beach</b> d. STREET ADDRESS <b>Riviera Beach, Md. 8513 Main Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Charles M. Beck</b>		4. DATE OF DEATH Month <b>2</b> Day <b>12</b> Year <b>66</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 9, 1904</b>	
9. AGE (in years last birthday) <b>61 yrs.</b>		10. IF UNDER 1 Year Months <b>2</b> Days <b>12</b> Hours <b>66</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>2nd. Heater</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Steel Making</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Charles E. Beck</b>		14. MOTHER'S MAIDEN NAME <b>Roberta ---</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>1920-1924</b>	
17. INFORMANT <b>Kathryn D. Beck - 8513 Main Ave.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO (b) <b>A-S-E-V- Disease</b> DUE TO (c) <b>Heart</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>None</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>M.B. Davis</b>		22. DATE SIGNED <b>2/17/66</b>	
EXAMINER'S NAME (Type) <b>M.B. Davis MD-6800</b>		23. DATE SIGNED <b>2/17/66</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 16, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR <b>George J. Gonce - 4001 Ritchie Hwy. - Balto.</b>		25a. REC'D BY REGISTRAR <b>FEB 17 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 and 6 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2, and 3 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

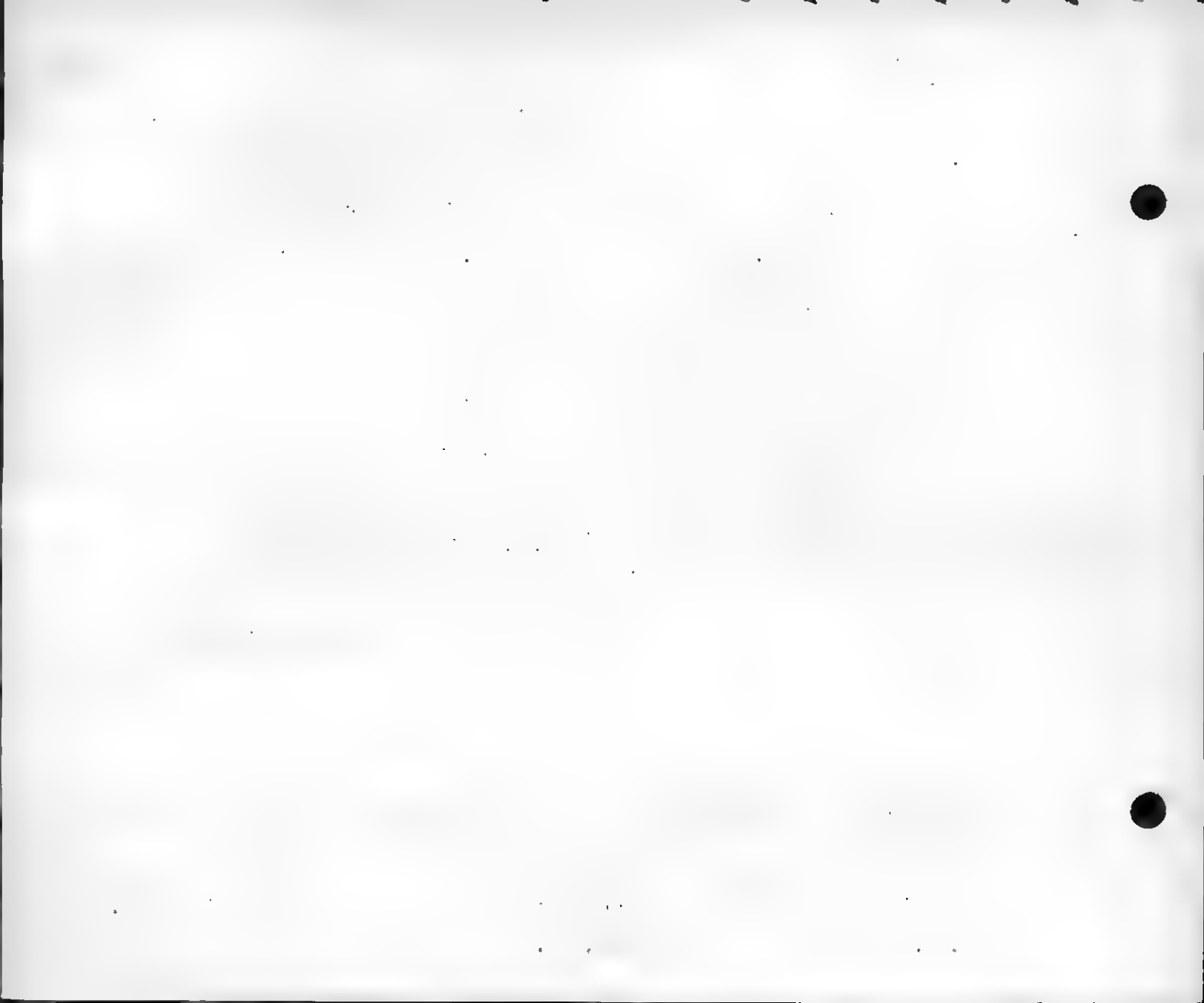
01813		01767	
1. PLACE OF DEATH a. COUNTY <u>Timonium</u> <u>Baltimore</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Timonium</u> <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Timonium</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Timonium</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>York Ridge Shopping Center</u>		d. STREET ADDRESS <u>202 Fountain Ct.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Grace Elizabeth BERRY</u>		4. DATE OF DEATH Month Day Year <u>February 11 1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-11-1920</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Professor-Goucher College</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>45</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Wallace L. Berry</u>		14. MOTHER'S MAIDEN NAME <u>Carrie G. Foster</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-05-3299</u>	
17. INFORMANT <u>Mrs Helen A. Darney</u>		Address <u>same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardio-vascular disease.</u> DUE TO (b) <u>4/2/31</u> DUE TO (c) <u>4/2/31</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not White at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Werner U. Spitz</u>		DATE SIGNED <u>Febr. 12, 1966</u>	
EXAMINER'S NAME (Type) <u>Werner U. Spitz, M.D.</u>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>2-15-66</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc Baltimore, Md.</u>		24a. REC'D BY REGISTRAR <u>FEB 15 1966</u>	
		24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <span style="float: right;">01813</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u> c. LENGTH OF STAY IN ID <u>3 mos + 22 days</u>				<b>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</b> a. STATE <u>Maryland</u> <span style="float: right;">01768</span> b. COUNTY <u>Somerset</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Deer Island</u>							
<b>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)</b> <u>Rosewood State Hospital</u>				<b>d. STREET ADDRESS</b> <u>Box 164</u>				<b>e. IS RESIDENCE ON A FARM?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED (Type or print)</b> <u>Tony</u>				<b>4. DATE OF DEATH</b> Month <u>2</u> Day <u>5</u> Year <u>1966</u>							
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>Negro</u>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>8-25-64</u>		<b>9. AGE (In years last birthday)</b> <u>1</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>	
<b>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b> <u>dependent</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>None</u>		<b>11. BIRTHPLACE (County &amp; State, or foreign country)</b> <u>Somerset, Maryland</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A</u>	
<b>13. FATHER'S NAME</b> <u>Clarence Arthur Bivens</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Henrietta Harris</u>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)</b> <u>No</u>				<b>16. SOCIAL SECURITY NO.</b> <u>None</u>		<b>17. INFORMANT</b> <u>Rosewood Record, Owings Mills, Maryland</u>					
<b>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</b> <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <u>Hydrocephalus - uncompensated</u> <u>7512</u> <b>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.</b> <b>(b)</b> <u>Sacral meningocele</u> <b>(c)</b> <u>Probab. also aspiration pneumonia</u>										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>5 months</u> <u>birth</u>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <u>Post A. V. Hunt; E. coli meningitis; flexed paraplegia</u>											
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>											
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)</b>											
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</b>		<b>20f. (City or town) (County) (State)</b>			
<b>21. I certify that (this hospital) attended the deceased from <u>10-14</u>, 19<u>65</u>, to <u>2-5</u>, 19<u>66</u>, that (we) last saw the deceased alive on <u>2-5</u> 19<u>66</u>, and that death occurred at <u>6:10 AM</u>, from the causes and on the date stated above.</b>											
<b>22a. SIGNATURE</b> <u>Barbara W. Keadon</u>						<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>2-5-66</u>			
<b>22c. PHYSICIAN'S NAME (Type)</b>						<b>22d. ADDRESS</b>					
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>2/11/66</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Rosewood Cemetery</u>		<b>23d. LOCATION (City, town or county) (State)</b> <u>Owings Mills, Md.</u>			
<b>24. FUNERAL DIRECTOR</b> <u>J. F. Eline &amp; Sons Reisterstown, Md.</u>						<b>25a. REC'D BY REGISTRAR</b> <u>FEB 14 1966</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>J. Charles Judge</u>			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01819		01769	
1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glen Arms, Md.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glen Arms, Md.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Back lot of the Pearce's residence		d. STREET ADDRESS Harford Rd. Near Hartley Mill Rd. C 2-1	
3. NAME OF DECEASED (Type or print) JOHN A MOS BLAKLEY		4. DATE OF DEATH 2-8-66	
5. SEX male		6. COLOR OR RACE white	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH June 10, 1923	
9. AGE (In years last birthday) 43 yrs.		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Service Station Attendant-Filling Station Maryland		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Clarence Elmer Blakely		14. MOTHER'S MAIDEN NAME Anna Elizabeth Finn	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No None		16. SOCIAL SECURITY NO. 216-18-6364	
17. INFORMANT Family records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Epilepsy and Laennec's cirrhosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Rudiger Breiteneker, M.D.		DATE SIGNED 2-9-66	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 12, 1966	
22c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park		22d. LOCATION (City, town, or country) (State) Parkville, Maryland	
23. FUNERAL DIRECTOR John Burns' Sons, Towson, Maryland		24a. REC'D BY REGISTRAR DATE FEB 14 1966	
24b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>BALTO</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>BALTO</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>	
c. LENGTH OF STAY IN ID		d. STREET ADDRESS <b>315 INGLETSIDE AVE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>FOREST HAVEN HOME</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ANNA E. BOTKOVSKY</b>		4. DATE OF DEATH Month <b>FEB</b> Day <b>7</b> Year <b>1966</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 20, 1882</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>CHEC.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>JOHN ZARCEK</b>		14. MOTHER'S MAIDEN NAME <b>ANNA SIMEC</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>HOSPITAL RECORDS</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cerebro-vascular accident</b> 221V Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>generalized arteriosclerosis</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>			INTERVAL BETWEEN ONSET AND DEATH <b>6 years 2 1/2</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>12/1, 1961</b> , to <b>1/26, 1966</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred at <b>5:15</b> AM, from the causes and on the date stated above.			
22a. SIGNATURE <b>W. K. Gallagher, Jr.</b>		22b. DATE SIGNED <b>8 FEB 5 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>W. K. Gallagher, Jr., M.D.</b>		22d. ADDRESS <b>6630 Baltimore National Pike - 28</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>2/11/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MT. OLIVET</b>	23d. LOCATION (City, town or county) (State) <b>WASH. D.C.</b>
24. FUNERAL DIRECTOR <b>E. S. MACNABB</b>		25a. REC'D BY REGISTRAR <b>FEB 10 1966</b>	
ADDRESS <b>301 FREDERICK RD 21228</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

MEDICAL CERTIFICATION



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

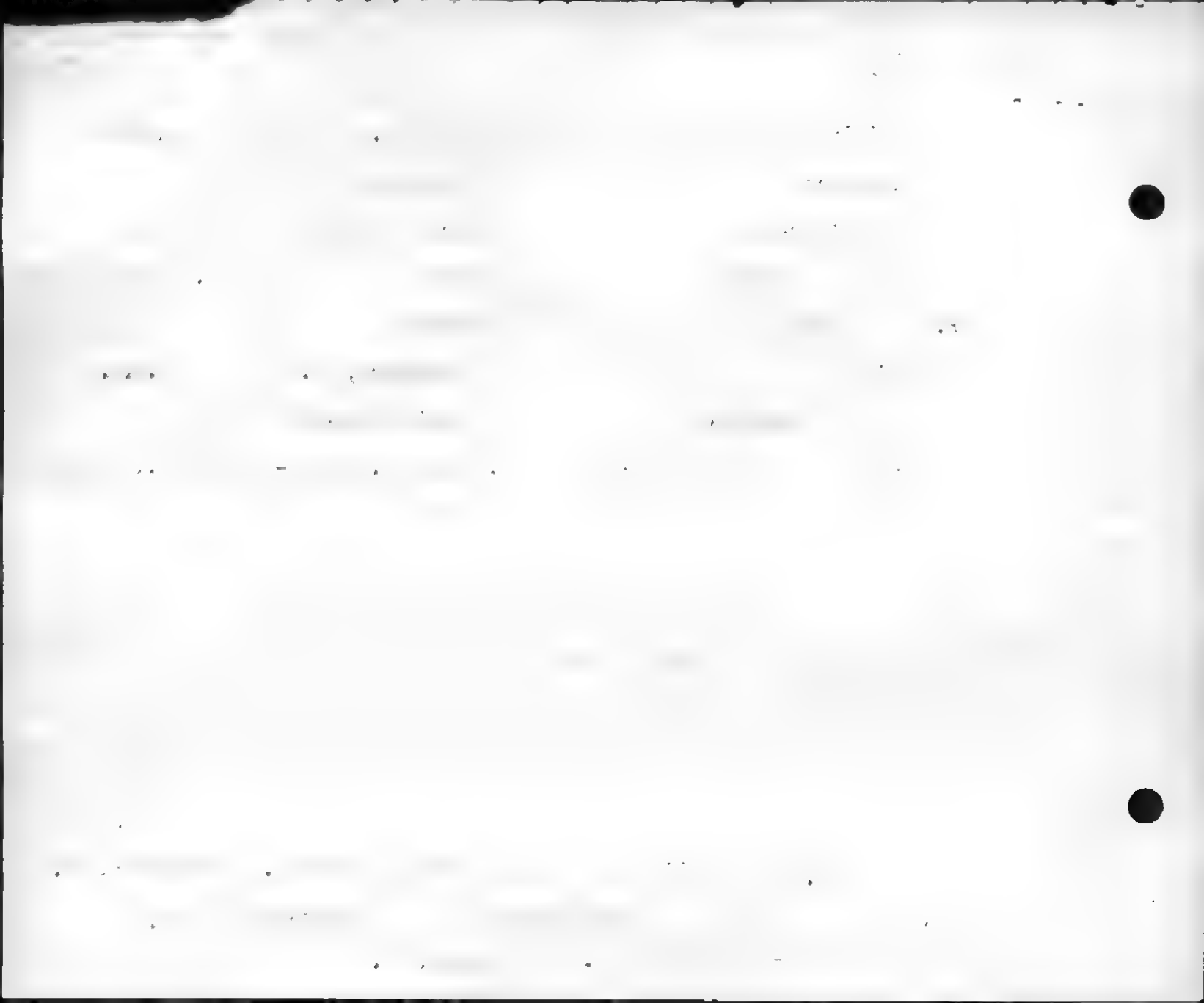
## CERTIFICATE OF DEATH

01771

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodstock</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodstock</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Summit Avenue</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Ruth</b> Middle <b>Bonsal</b> Last <b>Bonsal</b>			4. DATE OF DEATH Month <b>Feb.</b> Day <b>23</b> Year <b>1966</b>				
5. SEX <b>F.</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/6/1895</b>	9. AGE (In years last birthday) <b>70</b> yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	IF UNDER 24 HRS Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Woodstock, Md.</b>		12. CITIZEN OR WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Johnson</b>			14. MOTHER'S MAIDEN NAME <b>Mattie Chenoweth</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO <b>None</b>		17. INFORMANT <b>Mr. Albert R. Bonsal-Summit Ave., Woodstock</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarct</b> <b>260X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ASCVD</b> DUE TO (c) <b>Diabetes mellitus</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2/23</b> , 19 <b>66</b> , to <b>2/23</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>2/23</b> , 19 <b>66</b> , and that death occurred at <b>1 P.</b> M, from causes and on the date stated above.							
22a. SIGNATURE <b>[Signature]</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2/25/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Morton Ellin</b>				22d. ADDRESS <b>8629 Liberty Rd. Randallstown, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/26/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Good Shepherd</b>		23d. LOCATION (City or Town) (County) (State) <b>Ellicott City Md.</b>	
24. FUNERAL DIRECTOR <b>Loring Byers-8728 Liberty Rd. Randallstown, Md.</b>				25a. REC'D BY REGISTRAR <b>Feb 28 1966</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove pages 1 and 2 and return them to the funeral director, who should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any case, within 72 hours after death.

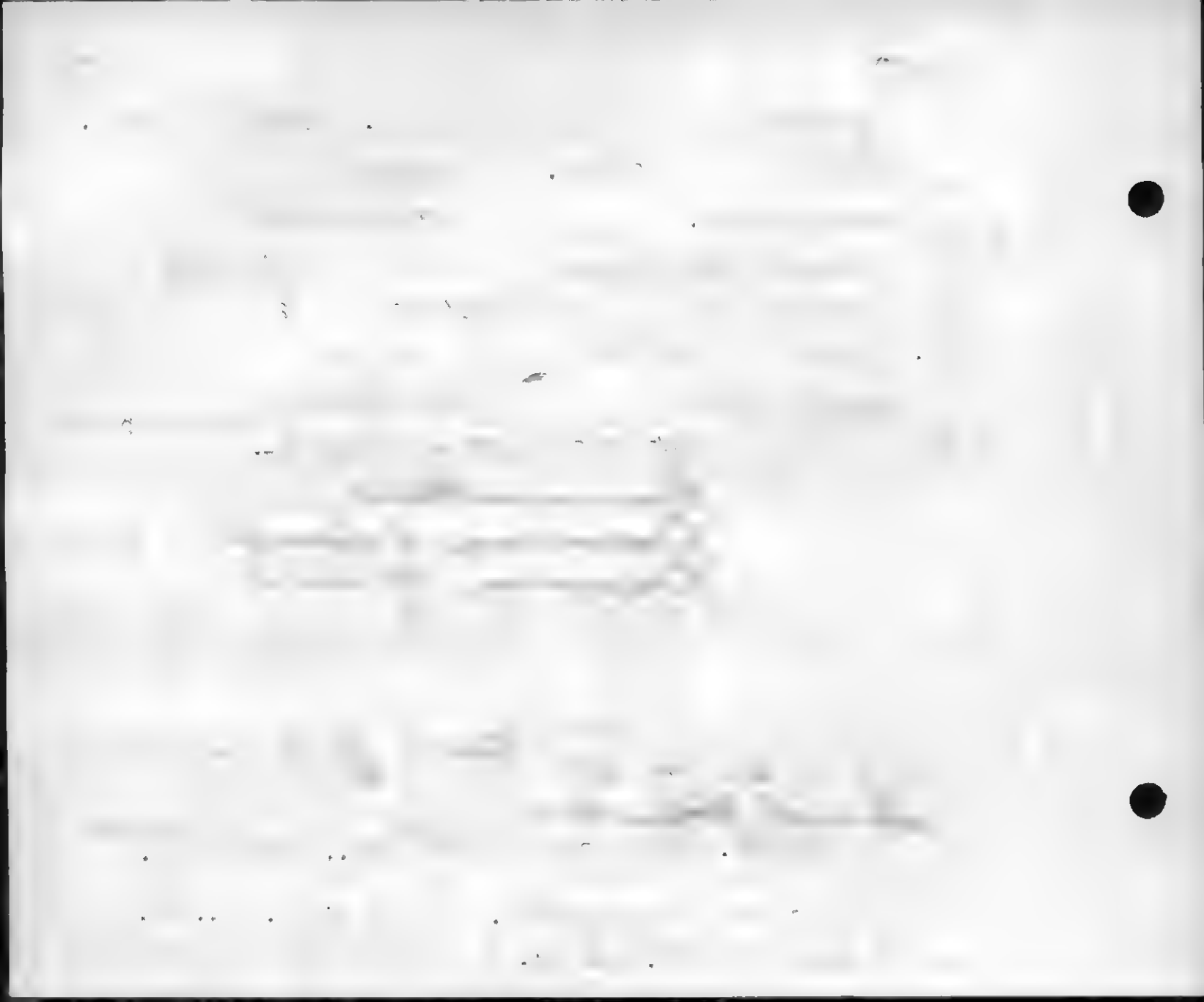


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DUNDALK</b> c. LENGTH OF STAY IN 1b <b>25 YRS.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>224 DETROIT AVE.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>BALTO.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DUNDALK</b> d. STREET ADDRESS <b>224 DETROIT AVE.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>CLARENCE VERNON BOSSOM</b> 5. SEX <b>MALE</b> 6. COLOR OR RACE <b>CAUCASIAN</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <b>9/25/1913</b> 9. AGE (In years last birthday) <b>52</b> yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LOCO. ENGINEER</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>RAILROAD</b> 11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b> 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		4. DATE OF DEATH <b>2/14/1966</b> 19 <b>19</b> 13. FATHER'S NAME <b>ABRAHAM BOSSOM</b> 14. MOTHER'S MAIDEN NAME <b>EDNA HALFPENNY</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> 16. SOCIAL SECURITY NO. <b>705/10/9620</b> 17. INFORMANT <b>BETTY WOMER BOSSOM--</b> Address <b>AS IN # 2 ABOVE</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Liver</b> DUE TO (b) <b>Carcinoma of Liver</b> DUE TO (c) <b>Carcinoma of Liver</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>6-8 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work et work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Dec 4, 1965</b> to <b>2-14, 1966</b> that (I) (we) last saw the deceased alive on <b>2-14, 1966</b> , and that death occurred at <b>8:00 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Samuel J. Hankin</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2/15/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>SAMUEL J. HANKIN</b> 22d. ADDRESS <b>3479 LIBERTY PKWY., DUNDALK, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b> 23b. DATE THEREOF <b>2/17/66</b> 23c. NAME OF CEMETERY OR CREMATORY <b>OAKLAWN CEM.</b> 23d. LOCATION (City, town or county) (State) <b>BALTO. CO., MD.</b>			
24. FUNERAL DIRECTOR <b>WALTER BROOKS BRADLEY</b> ADDRESS <b>DUNDALK, MD</b> 25a. REC'D BY REGISTRAR <b>FEB 17 1966</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



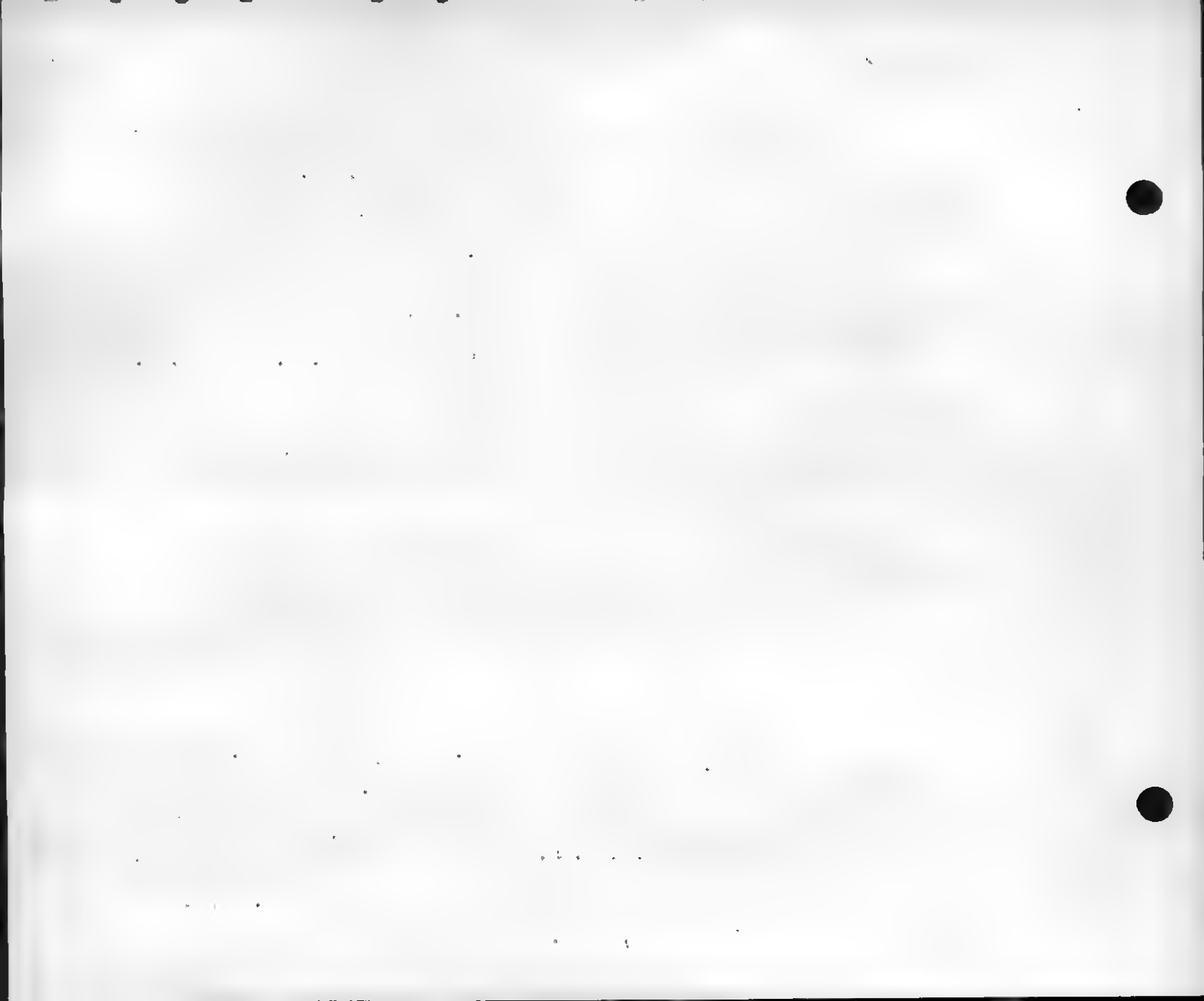
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Oxon Hill, Md.</b>	
c. LENGTH OF STAY IN 1b <b>4</b> days		d. STREET ADDRESS <b>5652 Alice Avenue</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Morgan</b> Last <b>Boteler</b>		4. DATE OF DEATH Month <b>February</b> Day <b>6</b> Year <b>1966</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 13, 1891</b>
9. AGE (in years last birthday) <b>74</b> yrs.		IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>James Morgan</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal pneumonia</b> DUE TO (b) <b>Generalized arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Old cerebrovascular accidents</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <del>no</del> (this hospital) attended the deceased from <b>Feb. 2, 1966</b> to <b>Feb. 6, 1966</b> , that <del>no</del> (we) last saw the deceased alive on <b>Feb. 6, 1966</b> , and that death occurred at <b>5:50</b> P. M. from the causes and on the date stated above.			
22a. SIGNATURE <b>Stella Wachsler</b>		22b. DATE SIGNED <b>2-6-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Stella Wachsler, M. D.</b>		22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>Feb. 10-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet</b>	23d. LOCATION (City, town or county) (State) <b>Wash. D.C.</b>
24. FUNERAL DIRECTOR <b>Thas. B. Hendon</b>		25a. REC'D BY REGISTRAR <b>14748 Wisc. Ave. N.W.</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles J. ...</b>		DATE <b>FEB 10 1966</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in space 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner. The original of this certificate may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Balto.</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Bal Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Randallstown</b>		c. LENGTH OF STAY IN TOWN <b>1 yr.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>Andrew Ralph Bowers</b>		4 DATE OF DEATH Month <b>Feb.</b> Day <b>11</b> Year <b>19 66</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Dec. 23, 1887</b>
9 AGE (In years, last birthday) <b>78</b> yrs		10 UNDER 1 YEAR Months <b>1</b> Days <b>11</b> Hours <b>19</b> Mins <b>66</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) <b>Frederick Co., Md.</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>Malcolm A. Bowers</b>		14 MOTHER'S MAIDEN NAME <b>Louise Jacobs</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16 SOCIAL SECURITY NO. <b>214-28-2311</b>	
17 INFORMANT <b>Mr. R. David Bowers, Middleburg, Md.</b>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic C-V Disease</b> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (b) stating the underlying cause lost (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>	
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b>none</b>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) <b>none</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>none</b> 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>D. D. Caples</b> EXAMINER'S NAME (Type) <b>D. D. Caples, M. D.</b>		22. DATE SIGNED <b>6 Hanover Rd., Randallstown, Md. 2-12-66</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>2-14-1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Lake View Mem.</b>		23d. LOCATION (City or town) (County) (State) <b>Carroll Co., Maryland</b>	
24. FUNERAL DIRECTOR <b>C. L. Waltz, Box 241, Sykesville, Md.</b>		25a. REC'D BY REGISTRAR <b>FEB 15 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01825

01775

1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
DOROTHY R. BOWERS.		9:10 AM 2-6-66	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND Baltimore County		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY MARYLAND (BALTIMORE COUNTY)	
FULL NAME OF HOSPITAL OR INSTITUTION Baltimore HOME: 8527 CHESTNUT OAK ROAD.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 34 D. STREET ADDRESS (If rural, give location) 8527 CHESTNUT OAK ROAD	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 10-17-18
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse		10B. KIND OF BUSINESS OR INDUSTRY Balto. Co. Schools	9. AGE (In years last birthday) 47
13. FATHER'S NAME BENJAMIN KAELIN		11. BIRTHPLACE (State or foreign country) Oregon Montana	
15. Was Deceased Ever in U. S. Armed Forces? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 544-22-8571	12. CITIZEN OF WHAT COUNTRY? USA
17. INFORMANT WALTER F. BOWERS. HUSBAND (Same)		ADDRESS	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cerebral Edema ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Primary Myocardial Disease		INTERVAL BETWEEN ONSET AND DEATH Minutes 3-4 years	
22. I certify that (I) (this hospital) attended the deceased from January 1965 to February 5, 1966, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
23A. SIGNATURE Katherine H. Borkovich		23B. DATE SIGNED Feb. 6, 1966	
23C. PHYSICIAN'S NAME (Type) KATHERINE H. BORKOVICH, M.D.		23D. ADDRESS BROADWAY 550 N. BROADWAY, BALTIMORE, MD. 21205	
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation	24B. DATE 2/10/66.	24C. NAME of CEMETERY or CREMATORY Greenmount Crematory	24D. LOCATION (City, town, or county) (State) Baltimore, Md.
25A. DATE REC'D BY HEALTH DEPT. FEB 9 1966		25B. NAME OF REGISTRAR 25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md. 21214	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE HEALTH DEPT.

01826

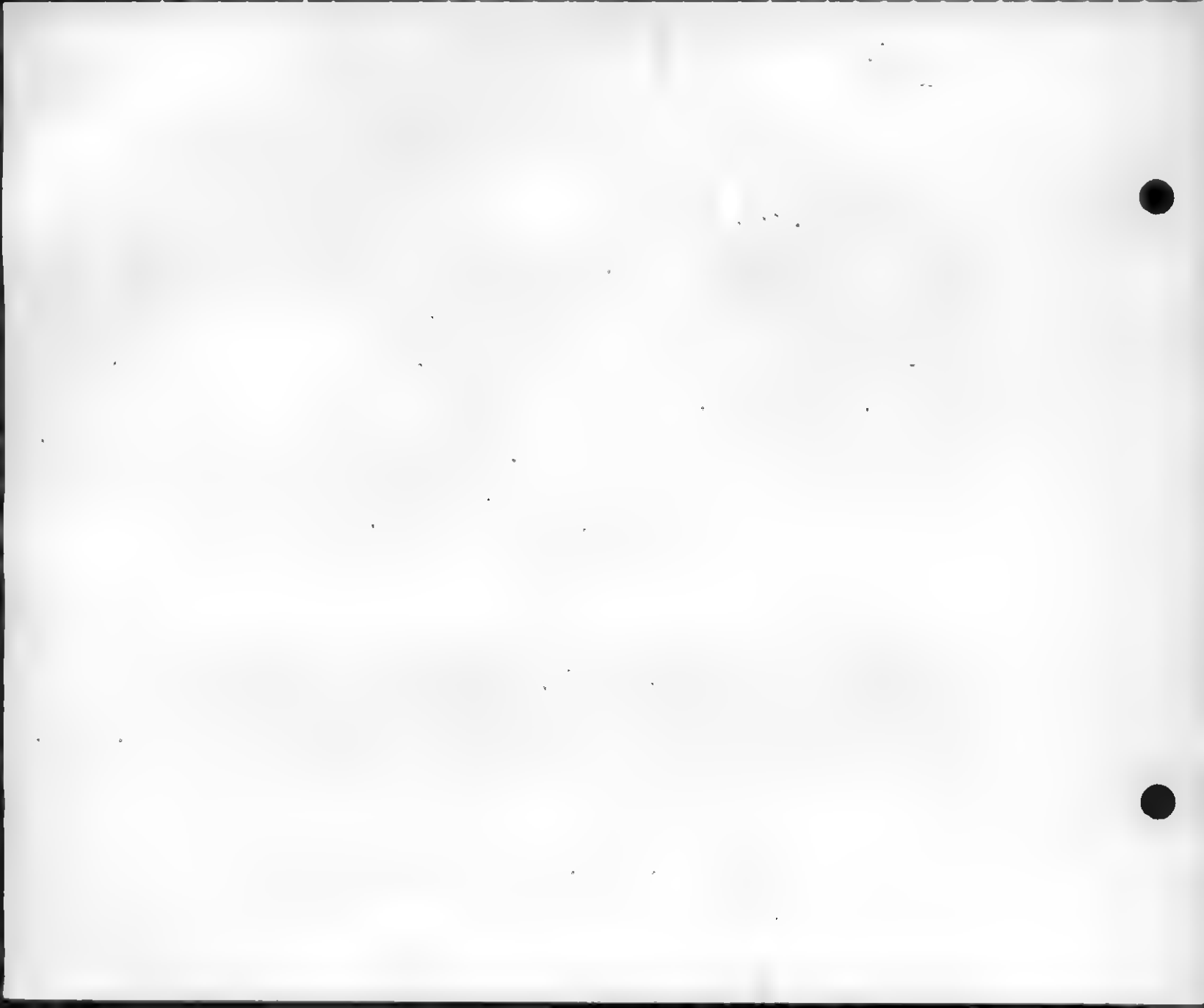
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

012726

1 PLACE OF DEATH a. COUNTY <b>Balto.</b> b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <b>Randallstown</b> c. LENGTH OF STAY in 1b <b>Woodlawn</b>		2 USUAL RESIDENCE (Where deceased lived if Institution or Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b> c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <b>Woodlawn</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Baltimore Co. Gen. Hospital</b>		d. STREET ADDRESS <b>5403 Pembroke Ave.</b>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>Dennis E. Bradford</b>		4 DATE OF DEATH Month Day Year <b>Feb. 26 1966</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>July 3, 1948</b>
9 AGE (in years last birthday) <b>17</b>		F UNDER 1 YEAR Months Days F UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>School</b>	
11 BIRTHPLACE (State or foreign country) <b>Penna.</b>		12 CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13 FATHER'S NAME <b>Harold L. Bradford, Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Eleanor J. Brown</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16 SOCIAL SECURITY NO	
17 INFORMANT <b>Mr. Harold L. Bradford, Sr.,</b>		Address <b>Woodlawn, Md. 5403 Pembroke Ave.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Fractured skull, Fractured ribs, Internal Hemorrhage, Multiple lacerations-rt. forehead &amp; L. occipital area</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>&amp; L. occipital area</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>10 min (est.)</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Car ran off rd., struck pole &amp; then fire hydrant.</b>	
20c. TIME OF INJURY Month, Day, Year <b>3:31 Hour Feb. 26, 1966</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home farm factory street office bldg, etc.) <b>Dogwood Rd.</b>	20f. (City or town) (County) (State) <b>Balto. 7 Balto. Md.</b>
21 I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>D. D. Caples</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>D. D. Caples, M. D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
6 Hanover Rd.,		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address is Precinct, City, Town, or County		22 DATE SIGNED <b>2-28-66</b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>March 1, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>	23d. LOCATION (City or Town) (County) (State) <b>Woodlawn Balto. Md.</b>
24 FUNERAL DIRECTOR <b>John T. Stansbury</b>		25a. RECD BY REGISTRAR <b>Windsor Mill Rd.</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		MAR 1 1966	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in the margin. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

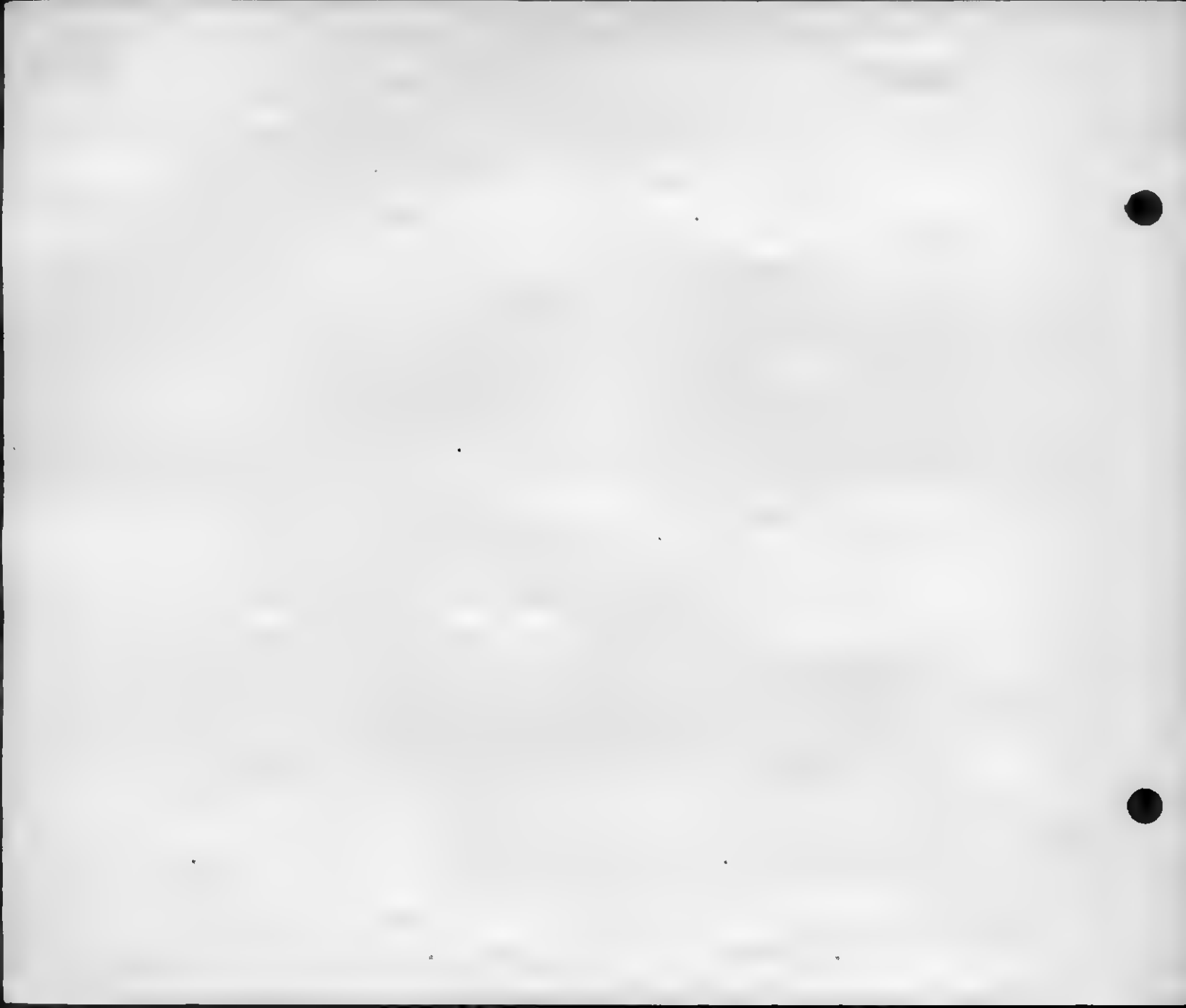
## CERTIFICATE OF DEATH

01827

01777

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u> c. LENGTH OF STAY IN 1b <u>2 months</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>8328 Loch Raven Blvd. 21204</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>New York</u> b. COUNTY <u>Queens</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgemere, Long Island</u> d. STREET ADDRESS <u>413 Beach 44th. Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>ADELINE MARY BRADY</u>		<b>4. DATE OF DEATH</b> Month Day Year <u>February 6, 1966</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <u>12/23/1928</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Home</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>New York</u>	
<b>13. FATHER'S NAME</b> <u>Frederick Grey</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Hanna Atfield</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>Mrs. C. J. Brenster 8328 Loch Raven Bl.</u>		<b>17. INFORMANT</b> Address <u>Mrs. C. J. Brenster 8328 Loch Raven Bl.</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> 142X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Hypertensive Intracerebral Cerebral Disease</u> (a), stating the underlying cause last. DUE TO (c) <u>10 yrs</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State) <u>Oct 23, 1957 to Feb 6, 1966</u>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Oct 23, 1957</u> <b>to</b> <u>Feb 6, 1966</u> <b>that (I) (we) last saw the deceased alive on</b> <u>Jan 19, 1966</u> <b>and that death occurred at</b> <u>5:30 P.M.</u> <b>from the causes and on the date stated above.</b>					
<b>22a. SIGNATURE</b> <u>Joseph F. LiPira M.D.</u>		<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <u>2/7/66</u>		<b>22b. DATE SIGNED</b>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Joseph F. LiPira M.D.</u>		<b>22d. ADDRESS</b> <u>6400 Loch Raven Blvd. 21204</u>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>2/9/66</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Woodlawn Cem.</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>William E. Johnson</u>		<b>ADDRESS</b> <u>3521 Loch Raven Blvd.</u>		<b>23d. LOCATION (City, town or county)</b> (State) <u>Woodlawn, Maryland</u>	
<b>25a. REC'D BY REGISTRAR</b> <u>Feb 8 1966</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

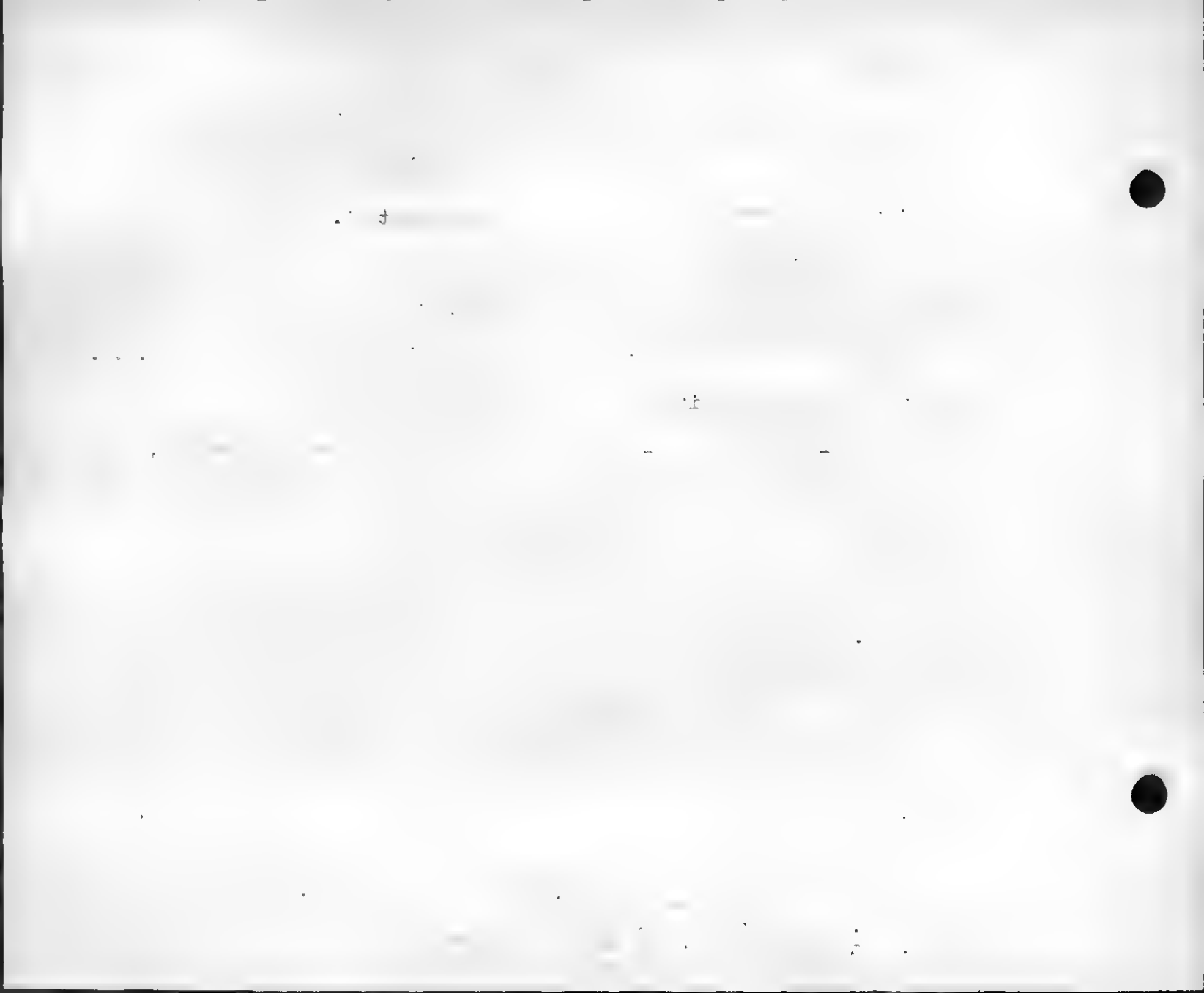
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01828

# CERTIFICATE OF DEATH

02778

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>		c. LENGTH OF STAY IN 1b <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Rosewood State Hospital</b>		d. STREET ADDRESS <b>1807 Belt St.</b>	
3. NAME OF DECEASED (Type or print) <b>Mary Brasavitch</b>		4. DATE OF DEATH Month <b>2</b> Day <b>18</b> Year <b>19 66</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/20/08</b>
9a. AGE (In years last birthday) <b>58</b> yrs.		9b. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore City</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Alphonse "Frank" Brasavitch</b>		14. MOTHER'S MAIDEN NAME <b>Martha Marschuk</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>-----</b>	
17. INFORMANT <b>Rosewood State Hospital Records, Owings Mills</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho pneumonia</b> <b>491X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hemiclegic epileptic idiot</b> 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (X) (this hospital) attended the deceased from <b>12/31</b> , 19 <b>15</b> , to <b>2/18</b> , 19 <b>66</b> , that (X) (we) last saw the deceased alive on <b>2/18</b> , 19 <b>66</b> , and that death occurred at <b>7:30 AM</b> , from the causes and on the date stated above. 22a. SIGNATURE <b>Barbara W. Hudson</b> 22b. DATE SIGNED <b>2/18/66</b> 22c. PHYSICIAN'S NAME (Type) 22d. ADDRESS 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b> 23b. DATE THEREOF <b>FEB.-22-1966</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Holy Trinity</b> 23d. LOCATION (City, town or county) (State) <b>ELK RIDGE MD.</b> 24. FUNERAL DIRECTOR <b>JOHN A. GREBLIAUCKAS</b> 24a. ADDRESS <b>604 S. MILTON AVE.</b> 24b. REC'D BY REGISTRAR <b>23 1966</b> 24c. REGISTRAR'S SIGNATURE <b>Charles J. [Signature]</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

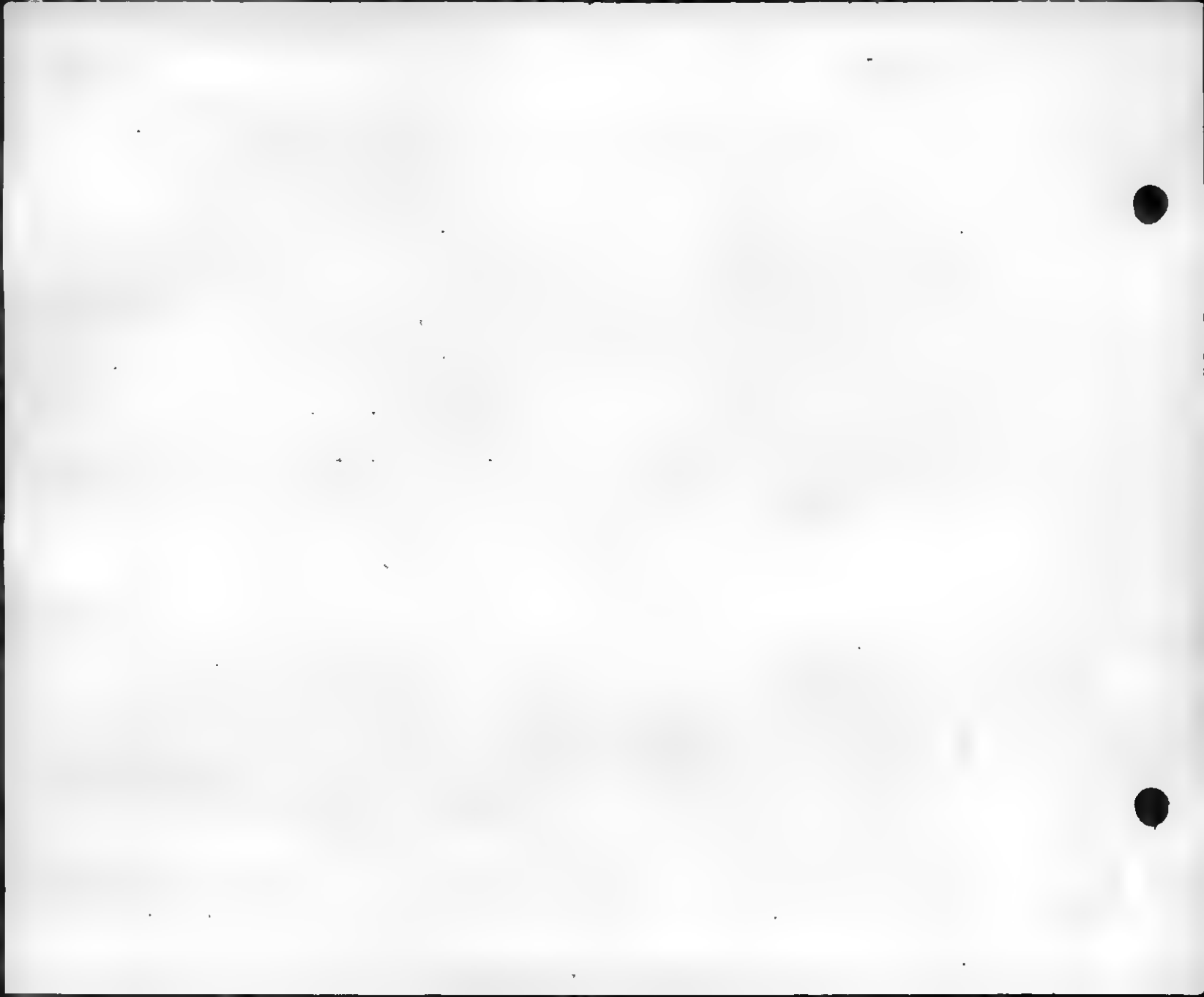
01829

## CERTIFICATE OF DEATH

01779

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b> c. LENGTH OF STAY IN 1b  d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rt. 1 Dover Road</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Baltimore</b></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b> <span style="float: right;">03-1</span> d. STREET ADDRESS <b>Rt. 1 Dover Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>DONALD WATSON BREWER</b> First Middle Last <b>5. SEX</b> <b>Male</b> <b>6. COLOR OR RACE</b> <b>White</b> <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <b>April 4, 1903</b> <b>9. AGE</b> (In years last birthday) <b>62</b> yrs <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Special Police</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Bendix</b> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>England</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>				<b>4. DATE OF DEATH</b> <b>February 23, 1966</b> Month Day Year <b>13. FATHER'S NAME</b> <b>Edwin George Brewer</b> <b>14. MOTHER'S MAIDEN NAME</b> <b>Matilda M. Watson</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		<b>16. SOCIAL SECURITY NO.</b> <b>217-22-2159</b>		<b>17. INFORMANT</b> <b>Mrs. Esther S. Brewer, Same as # 2</b> Address			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <b>Coronary Thrombosis</b> <b>4201</b> <b>DUE TO</b> <b>followed by degenerating</b> <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.</b> <b>(b) myocarditis - acute cardiac</b> <b>(c) infarction - final</b> <b>PART II. OTHER SIGNIFICANT CONDITIONS, CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <b>Heart became markedly hypertrophied with</b> <b>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year <b>19</b> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b> <b>21. I certify that (I) (this hospital) attended the deceased from 1-14-66, 19, to 2-23-1966, that (I) (we) last saw the deceased alive on 2-22-66, and that death occurred at 12:30 P.M. from causes and on the date stated above.</b> <b>22a. SIGNATURE</b> <b>James G. Saffell</b> <b>22b. DATE SIGNED</b> <b>22c. PHYSICIAN'S NAME (Type)</b> <b>James G. Saffell</b> <b>22d. ADDRESS</b> <b>Reisterstown Balto. Md.</b> <b>23a. BURIAL, CREMATION, RECEPTIONAL (Specify)</b> <b>Burial</b> <b>23b. DATE THEREOF</b> <b>Feb. 26, 1966</b> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Grace Methodist</b> <b>23d. LOCATION (City or Town) (County) (State)</b> <b>Baltimore Co., Md.</b> <b>24. FUNERAL DIRECTOR</b> <b>Wm. Cook-Brooks Towson, 1050 York Road, Towson, Md.</b> <b>25a. REC'D BY REGISTRAR</b> <b>FEB 23 1966</b> <b>25b. REGISTRAR'S SIGNATURE</b> <b>Charles Judge</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

01830

01280

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bowie, Maryland</u>	
c. LENGTH OF STAY IN 1b <u>1yr9mth9dys</u>		d. STREET ADDRESS <u>Fletcherstown Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lana</u> First <u>Brewer</u> Middle Last		4. DATE OF DEATH Month <u>February</u> Day <u>13</u> Year <u>1966</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 22, 1876</u>
9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Thad Blakly</u>		14. MOTHER'S MAIDEN NAME <u>Roxanna Wadsworth</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> <u>+ 200</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Uremia</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <u>10</u> (this hospital) attended the deceased from <u>May 4, 1964</u> to <u>Feb. 13, 1966</u> , that (if we) last saw the deceased alive on <u>Feb. 13, 1966</u> , and that death occurred at <u>7:30</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Stella Wachsler</u>		22b. DATE SIGNED <u>2-15-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Stella Wachsler, M. D.</u>		22d. ADDRESS <u>SPRING GROVE STATE HOSPITAL</u> <u>Baltimore, Maryland 21228</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>2/17/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CLINTON</u>	23d. LOCATION (City, town or county) (State) <u>SOUTH CAROLINA</u>
24. FUNERAL DIRECTOR <u>Denver Sax F. Home 816 H St NE Wash DC</u>		25a. REC'D BY REGISTRAR <u>FEB 16 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Michael Judge</u>	

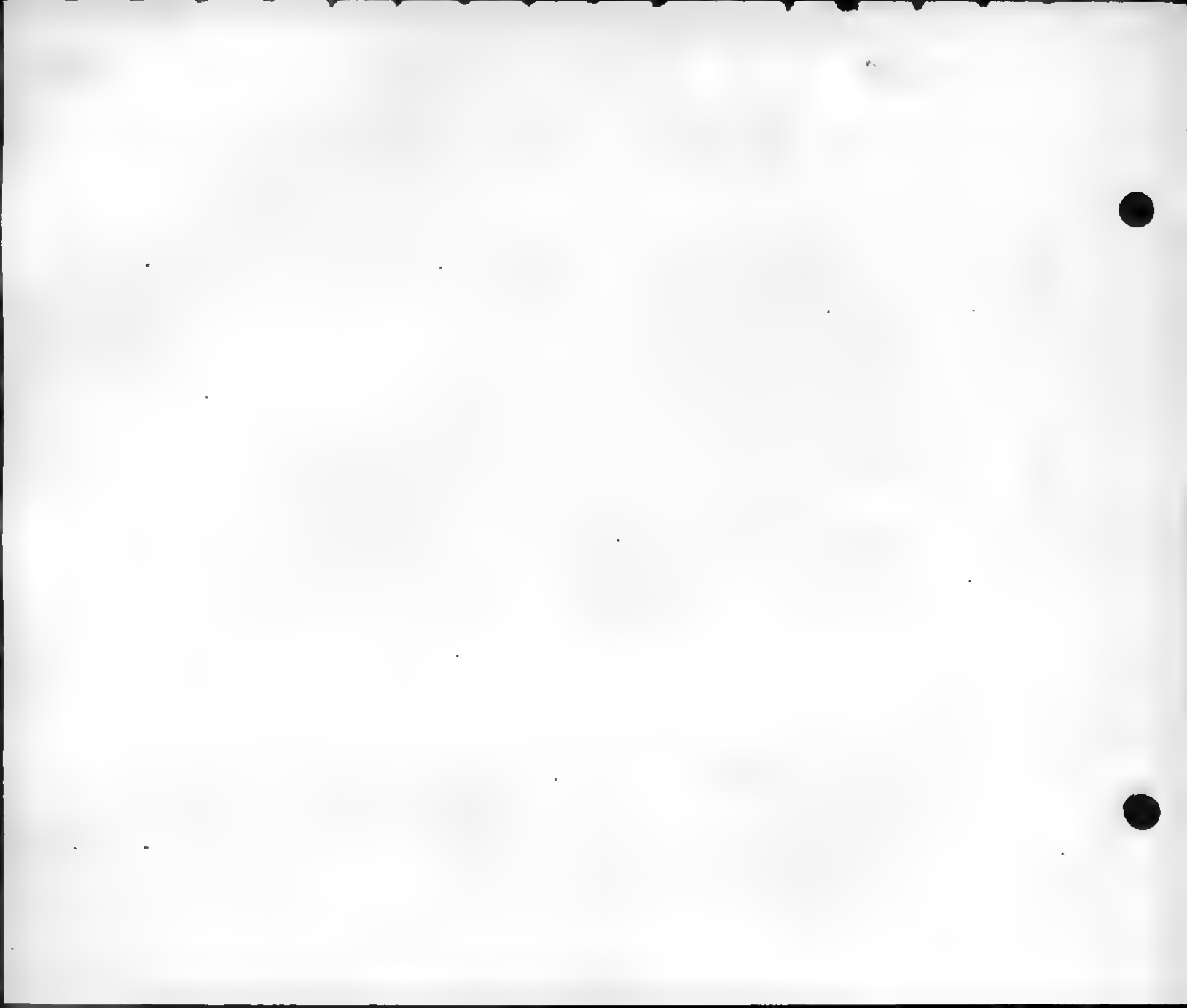


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE COUNTY</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Baltimore Medical Center</u>		d. STREET ADDRESS <u>416 Fairfax Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>CATHERINE DOLORES BRICE</u>		4. DATE OF DEATH <u>February 14</u> 19 <u>66</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-10-31</u>
9. AGE (In years last birthday) <u>35</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Edward Davis</u>		14. MOTHER'S MAIDEN NAME <u>Jennie Marie Strueman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Donald Brice</u>		Address <u>Baltimore Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary infarction</u> 171X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Thrombosis of vessels of Right leg</u> DUE TO (c) <u>Carcinoma of the cervix with metastasis</u>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <u>1-29</u> , 19 <u>66</u> to <u>2-14</u> , 19 <u>66</u> , that (1) (we) last saw the deceased alive on <u>2-14</u> , 19 <u>66</u> , and that death occurred at <u>6:20 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Filipina A. Silvestre</u>		22b. DATE SIGNED <u>2-14-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Filipina A. Silvestre</u>		22d. ADDRESS <u>Greater Baltimore Medical Center</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>		23b. DATE THEREOF <u>2-18-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Green Haven</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore</u>	
24. FUNERAL DIRECTOR <u>McCully-130 E Fort Ave.</u>		25a. REC'D BY REGISTRAR <u>FEB 16 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>W. H. Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

01832

01782

1. PLACE OF DEATH a. COUNTY <b>BALTO</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>16 FUSTING Ave Housewife</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>BALTO</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b> d. STREET ADDRESS <b>948 Masfield Rd</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>ANNA LOUISE BROWN</b>				4. DATE OF DEATH Month <b>2</b> Day <b>28</b> Year <b>1966</b>			
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12/27/1879</b>	
9. AGE (in years last birthday) <b>86</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.		IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>PRINCESS ANN Md</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>Edwin Pusey</b>				14. MOTHER'S MAIDEN NAME <b>KATHERINE E. DAVIS</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Edwin D. Brown 948 Masfield Rd</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1/28, 1953</b> , to <b>2/28, 1966</b> , that (I) (we) last saw the deceased alive on <b>2/26, 1966</b> , and that death occurred at <b>9:30 M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Robert A. Reiter</b> 22c. PHYSICIAN'S NAME (Type) <b>Robert A. Reiter, M.D.</b>						22b. DATE SIGNED <b>2/28/66</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22d. ADDRESS <b>606 Edmondson Ave - 28</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>3/3/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon PK</b>		23d. LOCATION (City, town or county) (State) <b>BALTO. Md</b>	
24. FUNERAL DIRECTOR <b>E. S. Mc Nab</b> ADDRESS <b>301 Franklin Rd</b>				25a. REC'D BY REGISTRAR <b>MAR 2 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 01783

01833

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Relay</u> c. LENGTH OF STAY IN 1b <u>38 years</u> d. NAME OF HOSPITAL (If not in hospital, give street address) <u>5169 Viaduct Ave</u>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Relay</u> d. STREET ADDRESS <u>5169 Viaduct Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>David</u> Middle <u>Irving</u> Last <u>Brown</u>		4. DATE OF DEATH Month <u>February</u> Day <u>6th</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 22 1880</u>
9. AGE (In years last birthday) <u>85 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Clerk</u>	11. BIRTHPLACE (State or foreign country) <u>Moorestown N.J.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Tom Brown</u>	
14. MOTHER'S MAIDEN NAME <u>Mary</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>—</u>	
16. SOCIAL SECURITY NO. <u>705-07-8878</u>		17. INFORMANT <u>Mrs Helen Meyer Brown</u> Address <u>5169 Viaduct Ave Relay Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Mitral Valvular Heart Disease</u> <u>41' X</u> DUE TO <u>Probable Rheumatic fever</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>Age Failure</u> DUE TO <u>Age Failure</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>See chart</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1937</u> , to <u>Feb. 6</u> , 1966, that I last saw the deceased alive on <u>Feb 5th</u> , 1966, and that death occurred at <u>5 PM</u> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>1014 Francis Ave Baltimore md (27)</u> DATE SIGNED <u>FEB 10 1966</u>			
ACTUAL SIGNATURE <u>FREDERICK V. BEITLER</u> M.D.			
PHYSICIAN'S NAME (Type) <u>FREDERICK V. BEITLER</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>Feb 10 1966</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Silverbrook Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Wilmington DE</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert H. Hargel</u> ADDRESS <u>201 S. Mt Airy</u>		24. PREPARED BY REGISTRAR <u>FEB 10 1966</u> 24b. REGISTRAR'S SIGNATURE <u>Charles J. Hargel</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy of this certificate and return it to the registrar.

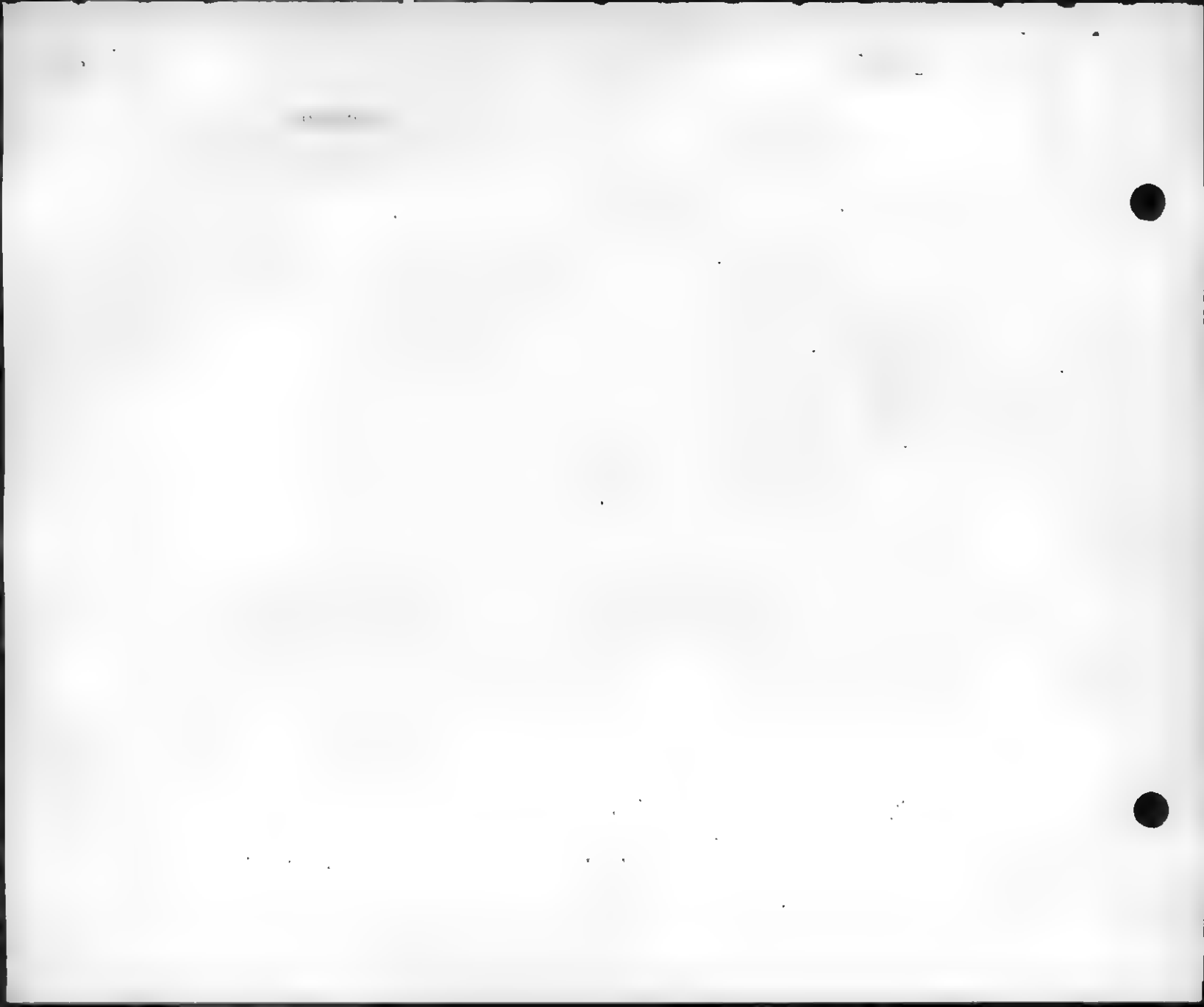


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
01834 CERTIFICATE OF DEATH 01784									
1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>1</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>			c. LENGTH OF STAY IN 1b <u>42 YRS. 1 Mo. 14 Days</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>					d. STREET ADDRESS <u>unknown</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>BROWN</u> Last <u>BROWN</u>					4. DATE OF DEATH Month <u>FEBRUARY</u> , Day <u>23</u> , Year <u>1966</u>				
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1891</u>		9. AGE (In years last birthday) <u>74</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>hat cleaner</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>GREECE</u>		12. CITIZEN OF WHAT COUNTRY? <u>Greece</u>	
13. FATHER'S NAME <u>unknown</u>					14. MOTHER'S MAIDEN NAME <u>unknown</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>			16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>HOSPITAL RECORDS</u> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC FAILURE (RIGHT SIDE)</u> DUE TO (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) <u>EMPHYSEMA</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>1, 9, 1924</u> , to <u>2, 23, 1966</u> , that (I) (we) last saw the deceased alive on <u>2/23/1966</u> , and that death occurred at <u>11</u> A.M. from the causes and on the date stated above.									
22a. SIGNATURE <u>Imre Kopits</u> (K-777) M.D.					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>2-24-66</u>		
22c. PHYSICIAN'S NAME (Type) <u>Imre Kopits, M. D.</u>					22d. ADDRESS <u>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE THEREOF <u>2/20/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GREEK CATHODOX</u>		23d. LOCATION (City, town or county) (State) <u>WOODLAWN, BALTO., MD.</u>		
24. FUNERAL DIRECTOR <u>W. COOK-BROOKS INC., 1217 N. T. PAUL ST., BALTO., MD.</u>					25a. REC'D BY REGISTRAR <u>DATE FEB 28 1966</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

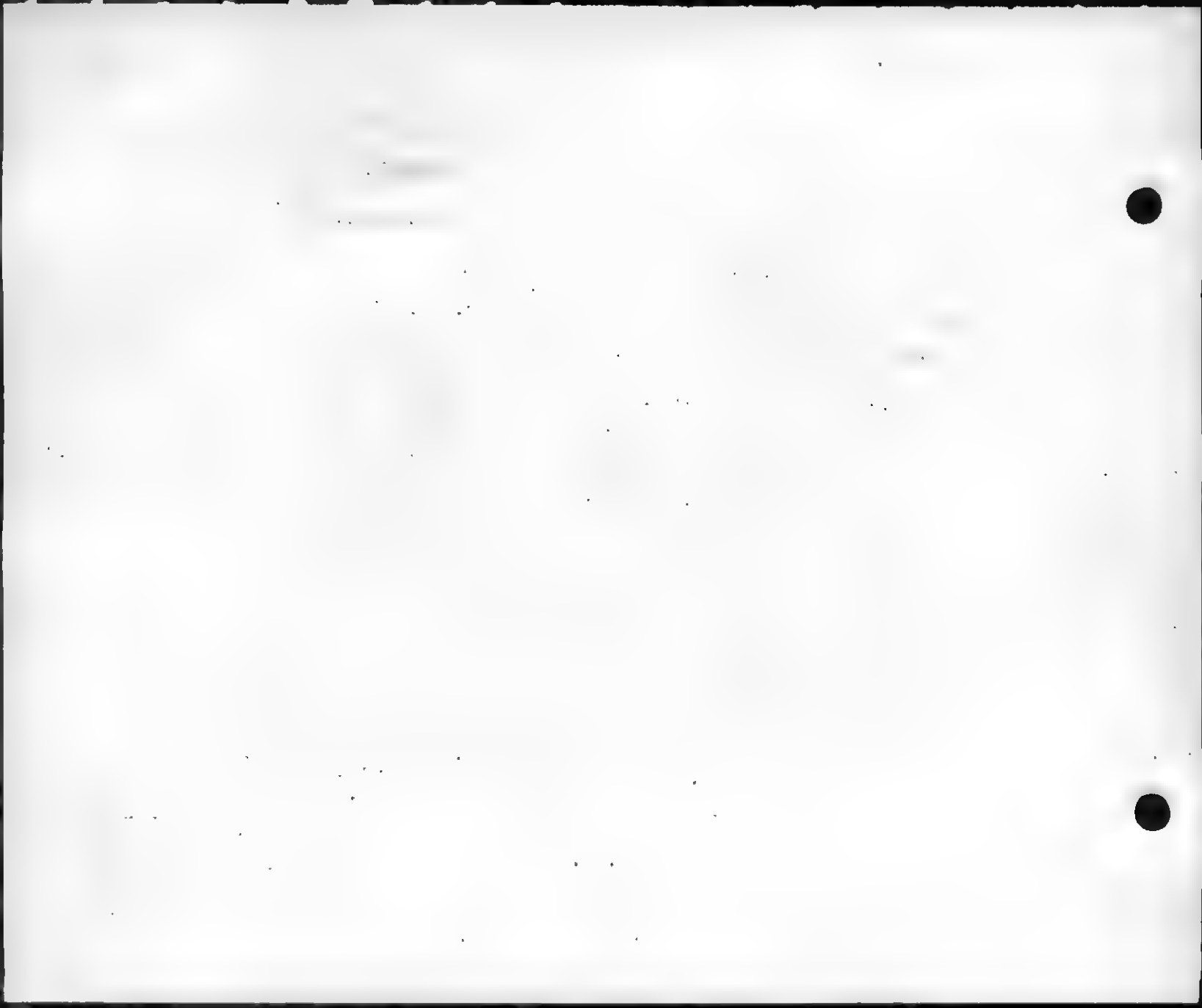
## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

### CERTIFICATE OF DEATH

01835

01835

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> <span style="float: right;">c. LENGTH OF STAY IN 1b</span> <u>6 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Baltimore</u></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore, Maryland - CATONSVILLE</u> d. STREET ADDRESS <u>4 N. SYMINGTON AVE.</u> <u>2 Newship Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
NAME OF DECEASED (Type or print) First <u>Grace</u> Middle <u>C.</u> Last <u>Burford</u>			<b>4. DATE OF DEATH</b> Month <u>February</u> Day <u>7</u> Year <u>19 66</u>				
<b>5. SEX</b> <u>female</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <u>Dec. 27, 1910</u>		<b>9. AGE</b> (In years last birthday) <u>55</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>unknown STENOGRAPHER</u>			
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>RAILWAY BROTHERHOOD</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>unknown MD.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>unknown</u>			
<b>13. FATHER'S NAME</b> <u>unknown WILLIAM A. BURFORD</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>unknown GRACE WALLACE</u>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <u>unknown</u>		<b>16. SOCIAL SECURITY NO.</b> <u>none</u>		<b>17. INFORMANT</b> <u>Records: SPRING GROVE STATE HOSPITAL</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular collapse</u> <u>1721</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					<b>INTERVAL BETWEEN ONSET AND DEATH</b> _____		
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____			
<b>20f. (City or town)</b> _____		<b>20g. (County)</b> _____		<b>20h. (State)</b> _____			
<b>21. I certify that</b> <u>(X)</u> (this hospital) attended the deceased from <u>Feb. 1</u> , 19 <u>66</u> , to <u>Feb. 7</u> , 19 <u>66</u> , that <u>we</u> last saw the deceased alive on <u>Feb. 7</u> , 19 <u>66</u> , and that death occurred at <u>6:20</u> M, from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <u>F. Kobler</u>				<b>22b. DATE SIGNED</b> <u>2-7-66</u>			
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Fritz Kobler, M. D.</u>				<b>22d. ADDRESS</b> <u>SPRING GROVE STATE HOSPITAL</u> <u>Baltimore, Maryland 21228</u>			
<b>23a. BURIAL, CREMAT, OR REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>2-10-66</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Cathedral Cem.</u>			
<b>23d. LOCATION</b> (City, town or county) <u>Baltimore, Md.</u>		<b>23e. (State)</b> _____					
<b>24. FUNERAL DIRECTOR</b> <u>Harley Coonough</u>				<b>25a. REC'D BY REGISTRAR</b> <u>Charles Judge</u>			
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>				<b>DATE</b> <u>FEB 11 1966</u>			

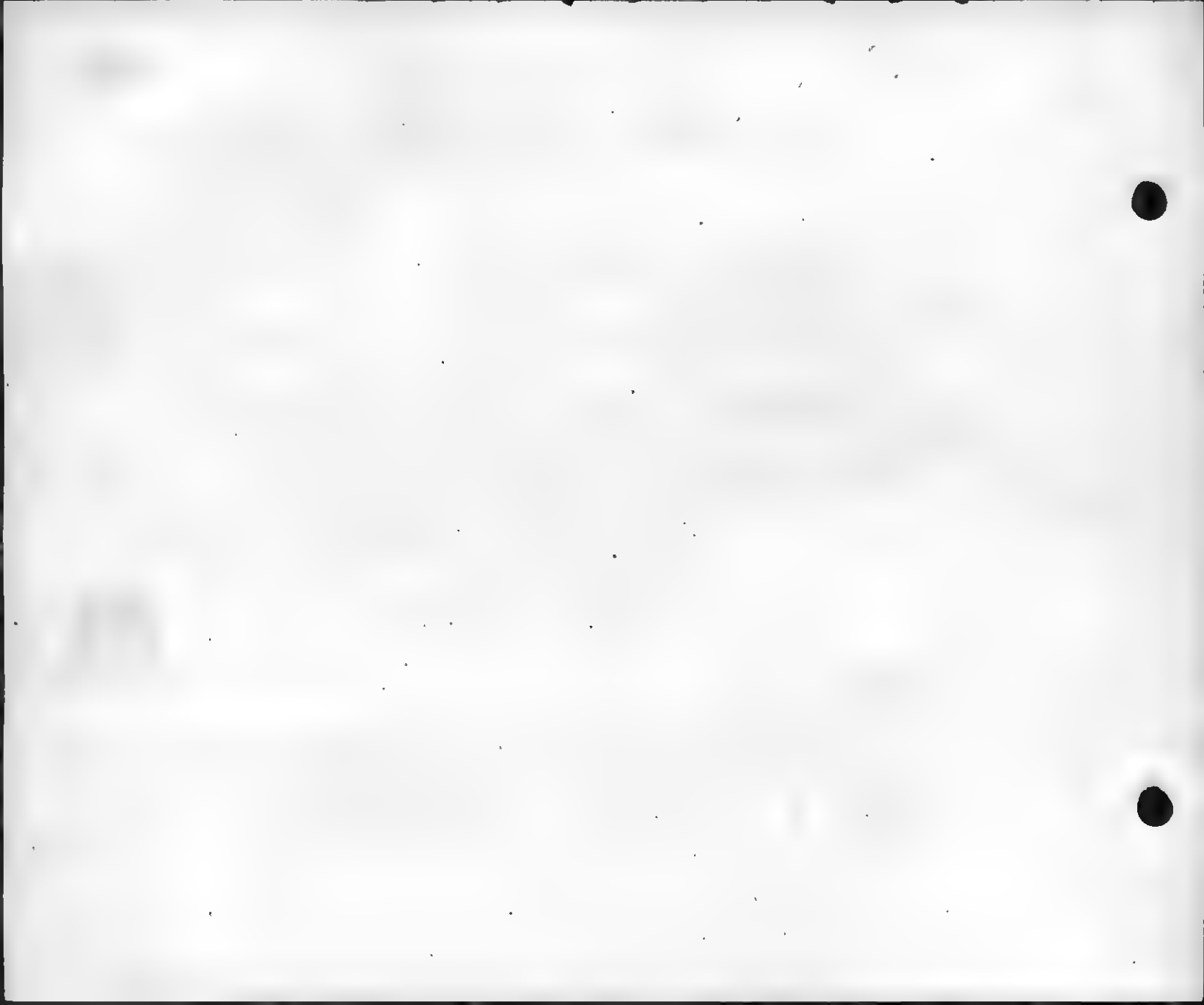


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																			
01836					CERTIFICATE OF DEATH					02052									
1. PLACE OF DEATH a. COUNTY <b>BALTIMORE County Gen Hosp MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>M.D.</b> b. COUNTY <b>BALTIMORE</b>														
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Randallstown</b>					c. LENGTH OF STAY IN 1b <b>1 DAY</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WOODLAWN</b>									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>BALTIMORE County Gen Hosp</b>					d. STREET ADDRESS <b>2015 Kennicott Rd</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last <b>EDWARD JOHN Butler</b>					4. DATE OF DEATH Month Day Year <b>FEB 1 1966</b>														
5. SEX <b>Male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MAY 20 65</b>		9. AGE (in years last birthday) yrs. <b>8</b> Months <b>11</b> Days <b>11</b> Hours <b>Min.</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>		10b. KIND OF BUSINESS OR INDUSTRY							
11. BIRTHPLACE (County & State, or foreign country) <b>BALTIMORE + 65-12690 USA</b>					12. CITIZEN OF WHAT COUNTRY? <b>USA</b>														
13. FATHER'S NAME <b>Joseph Albert Butler</b>					14. MOTHER'S MAIDEN NAME <b>GALLAGHER</b>														
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>					16. SOCIAL SECURITY NO. <b>None</b>					17. INFORMANT <b>Joseph Albert Butler</b> Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CRIB DEATH</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>CHRONIC BRAIN DAMAGE &amp; MICROCEPHALY</b> DUE TO (c) <b>FAILURE TO THRIVE</b>										INTERVAL BETWEEN ONSET AND DEATH <b>Since Birth</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Released by Dept of Medical Examiners</b>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>FOR BALTIMORE COUNTY BY D. P. CAPLES M.D.</b>														
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
					20f. (City or town) (County) (State) <b>Baltimore, Maryland</b>														
21. I certify that (I) (this hospital) attended the deceased from <b>5 - 20, 1965</b> to <b>2 1, 1966</b> , that (I) (was) last saw the deceased alive on <b>2 1 1966</b> , and that death occurred at <b>430 M</b> , from the causes and on the date stated above.																			
22a. SIGNATURE <b>Edwin H. T. Besson</b> M.D.										22b. DATE SIGNED <b>2.1.66</b>									
22c. PHYSICIAN'S NAME (Type) <b>EDWIN H. T. BESSON</b>										22d. ADDRESS <b>804 3 Ingleside AVE 21225</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					23b. DATE THEREOF <b>2/3/66</b>					23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>									
					23d. LOCATION (City, town or county) (State) <b>Baltimore, Maryland</b>														
24. FUNERAL DIRECTOR <b>Ellsworth Armacost</b> ADDRESS <b>4600 Liberty Heights Ave</b>										25a. REC'D BY REGISTRAR <b>FLC 1</b>					25b. REGISTRAR'S SIGNATURE <b>1966</b>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be exempted within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

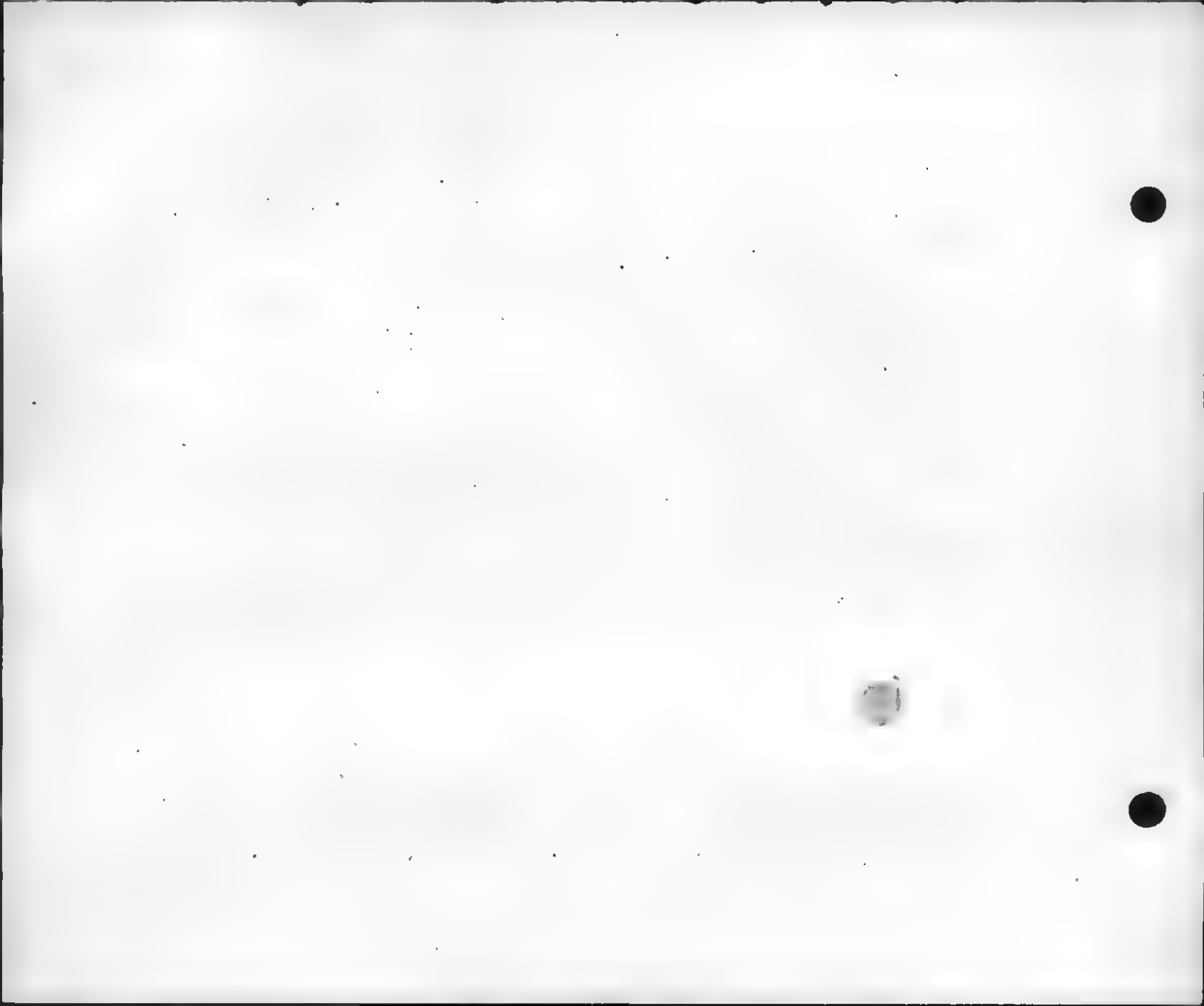
M

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

01837

01786

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Mount Wilson</b>				c. LENGTH OF STAY IN 1b <b>2 mo.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Mount Wilson State Hospital</b>				d. STREET ADDRESS <b>824 N. Wolfe St</b>			
3. NAME OF DECEASED (Type or print) <b>PROVIDENCE (GUY) BUTTS</b>				4. DATE OF DEATH Month <b>2</b> Day <b>26</b> Year <b>1966</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>N</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9.17.1903</b>	9. AGE (in years last birthday) <b>62</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Steelworker</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>TRAVIS BUTTS</b>			
14. MOTHER'S MAIDEN NAME <b>MYRTLE POWELL</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or, unknown) (If yes give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>213-09-1174</b>				17. INFORMANT <b>Hosp. records, Mt. Wilson State Hospital</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Lung</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pulmonary tuberculosis</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>19</b> p.m.				20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from <b>2.24.1965</b> to <b>2.26.1966</b> , that (I) (we) last saw the deceased alive on <b>2.26.1966</b> , and that death occurred at <b>6:20 a.m.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Wm. Newcomer</b>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <b>Wm. Newcomer, M.D., Superintendent</b>	
22d. ADDRESS <b>Mount Wilson, Maryland</b>				23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			
23b. DATE THEREOF <b>March 2/66</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Mem. Park</b>			
23d. LOCATION (City, town or county) (State) <b>Arbutus Md.</b>				24. FUNERAL DIRECTOR <b>ELLIOTT FUN. HOME N. CAROLINE ST</b>			
25a. REC'D BY REGISTRAR <b>FEB 28 1966</b>				25b. REGISTRAR'S SIGNATURE <b>J. Stanley Jorgie</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

01838

MARYLAND STATE DEPARTMENT OF HEALTH

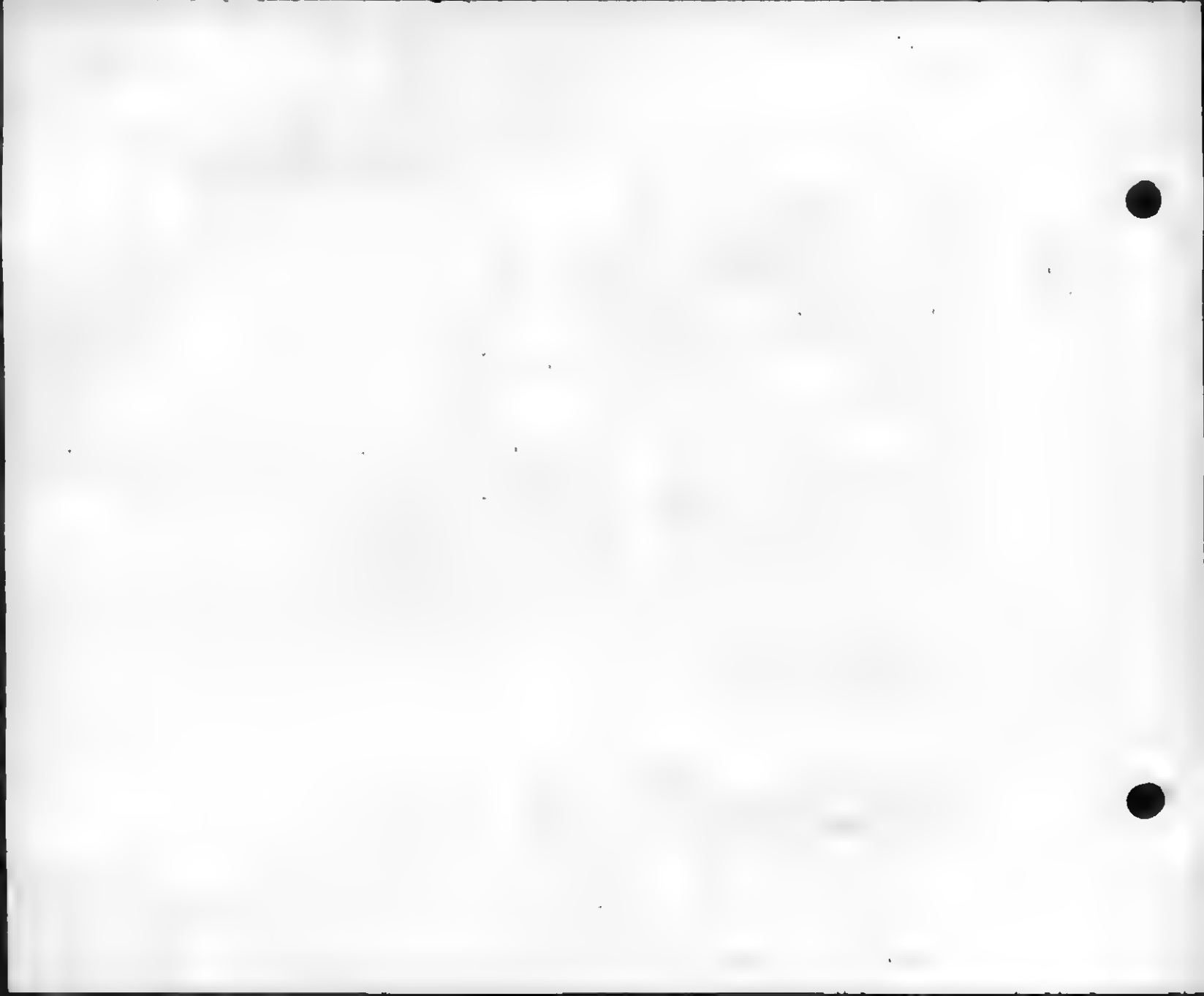
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01787

Item #230-1111-4313 2/14/66

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b> c. LENGTH OF STAY IN b. <b>15 YEARS</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>203 AIGBIRTH RD</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>203 AIGBIRTH RD TOWSON</b> d. STREET ADDRESS <b>203 AIGBIRTH RD</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>EDWARD</b> Middle <b>BARTLETT</b> Last <b>CALLAHAN</b>		4. DATE OF DEATH Month <b>FEB</b> Day <b>9</b> Year <b>1966</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOV 18, 1891</b>
9. AGE (In years last birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>9</b> Hours <b>14</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>OPERATOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>TRANSIT CO.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>BALTIMORE, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>LAWRENCE CALLAHAN</b>		14. MOTHER'S MAIDEN NAME <b>MARY O'CONNELL</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-10-0459</b>	
17. INFORMANT <b>Mrs ELIZ. KIRBY</b>		Address <b>203 AIGBIRTH RD TOWSON, MD. 21204</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma</b> <b>104X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>of Lung</b> DUE TO (c) <b>of Carcinoma of Rectum</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 yr 2 mos</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1/10, 1959</b> to <b>2/9, 1966</b> , that (I) last saw the deceased alive on <b>2/4 1966</b> , and that death occurred at <b>M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Edw. Bartlett Callahan</b>		22b. DATE SIGNED	22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
<b>BURIAL</b>	<b>2-12-66</b>	<b>MT. SARAH CEMETERY</b>	<b>HAVER DE GRACE, MARYLAND</b>
24. FUNERAL DIRECTOR <b>Wm. C. Brooks</b>		25a. REC'D BY REGISTRAR <b>2/14 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Phyllis Judge</b>

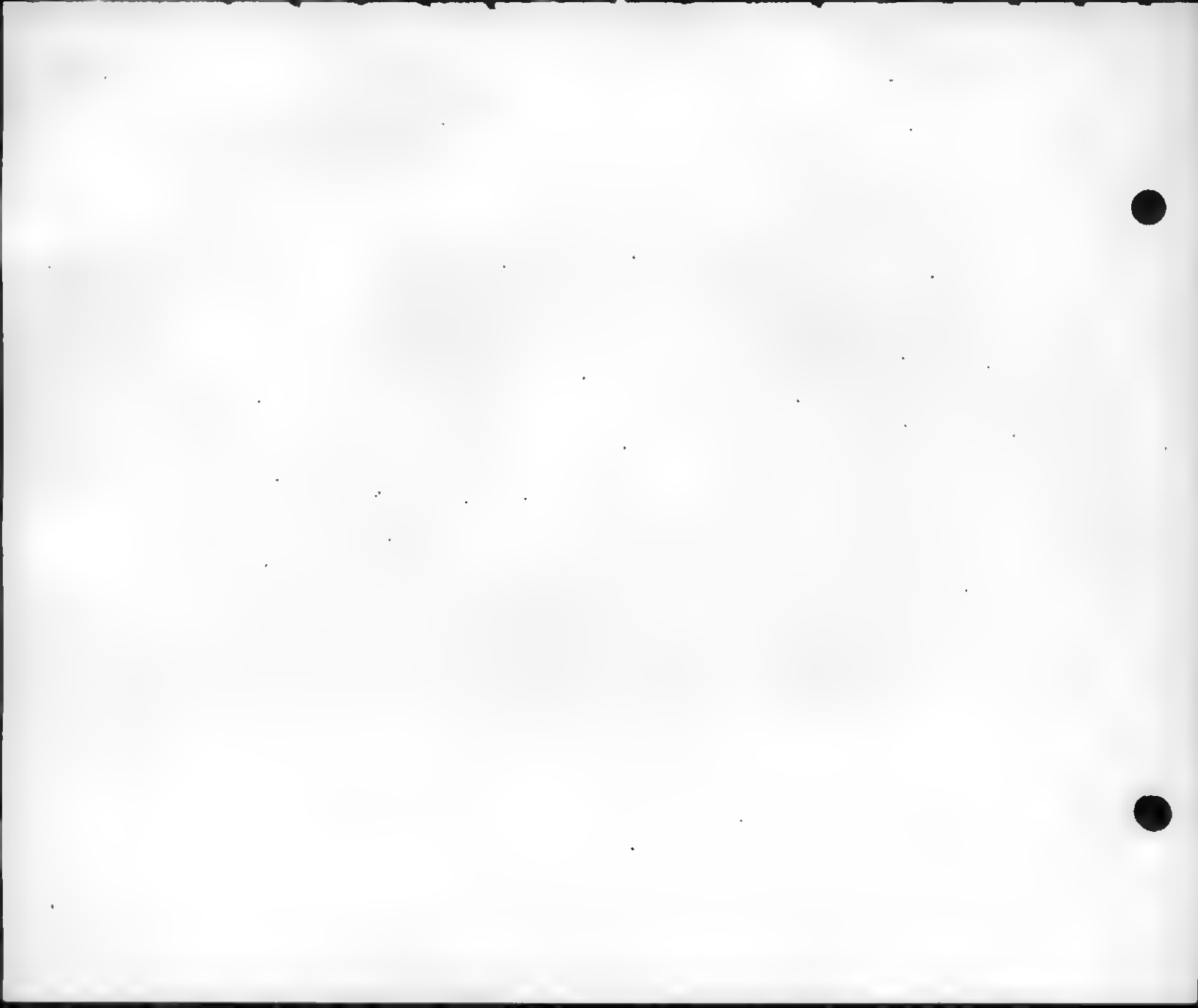


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																			
01839					CERTIFICATE OF DEATH					01788									
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> c. LENGTH OF STAY IN 1b <b>Life</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Greater Baltimore Medical Center</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Kingsville</b> d. STREET ADDRESS <b>Kingsville</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
3. NAME OF DECEASED (Type or print) <b>WILDA 13 CAMPBELL</b>					4. DATE OF DEATH Month <b>Feb.</b> Day <b>22</b> Year <b>1966</b>														
5. SEX <b>F</b>					6. COLOR OR RACE <b>CAU</b>					7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>									
8. DATE OF BIRTH <b>5-20-06</b>					9. AGE (In years last birthday) <b>59</b> yrs.					10. IF UNDER 1 YEAR (If under 24 HRS. Months Days Hours Min.)									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>					11. BIRTHPLACE (County & State, or foreign country) <b>Upper Falls, Md.</b>									
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					13. FATHER'S NAME <b>William W. Bell</b>					14. MOTHER'S MAIDEN NAME <b>Bertha Standford</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>					16. SOCIAL SECURITY NO. <b>None</b>					17. INFORMANT <b>Patient's chart</b> Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Malignant lymphoma with</b> <b>2002</b> <b>wide spread metastases</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town)					20g. (County)					20h. (State)									
21. I certify that (I) (this hospital) attended the deceased from <b>2-10</b> , 1966, to <b>2-22</b> , 1966, that (I) (we) last saw the deceased alive on <b>2-22</b> , 1966, and that death occurred at <b>3:15</b> P.M. from the causes and on the date stated above.																			
22a. SIGNATURE <b>F. A. IRANI</b>										22b. DATE SIGNED <b>2-22-66</b>									
22c. PHYSICIAN'S NAME (Type) <b>F. A. IRANI</b>										22d. ADDRESS <b>Kingsville</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					23b. DATE THEREOF <b>2-25-1966</b>					23c. NAME OF CEMETERY OR CREMATORY <b>Hopewell Cemetery</b>									
23d. LOCATION (City, town or county) <b>Woodlawn</b>					23e. (State) <b>Md.</b>					23f. (Country)									
24. FUNERAL DIRECTOR <b>Lassahn Funeral Home 7401 Belair Rd. 21236</b>										25a. REC'D BY REGISTRAR <b>Feb 25 1966</b>					25b. REGISTRAR'S SIGNATURE <b>W. H. Dudge</b>				



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01840

01789

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
c. LENGTH OF STAY IN ID <b>30yr11mth9dys</b>		d. STREET ADDRESS <b>1305 Valley Street</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Catherine</b>		4. DATE OF DEATH Month <b>February</b> Day <b>23</b> Year <b>1966</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 1887</b>
9. AGE (In years last birthday) <b>78 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>John Edward Schley</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Morgan</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFIRMARY <b>Records: SPRING GROVE STATE HOS PITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized arteriosclerosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus - Frac. of left femur</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>pt. found with impacted fracture of left hip; cause unknown</b>			
20c. TIME OF INJURY Hour <b>5:45pm</b> a.m. <b>2-3</b> 19 <b>66</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>hospital</b>		20f. (City or town) (County) (State) <b>Baltimore, Maryland</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>George M. Kieffer</i>		22. DATE SIGNED <b>2-24-66</b>	
EXAMINER'S NAME (Type) <b>George M. Kieffer, M. D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>1010 Leeds Avenue, Balto.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>3/4/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>	23d. LOCATION (City, town or county) (State) <b>old Frederick Rd., Balto., Md.</b>
24. FUNERAL DIRECTOR <b>Krause Funeral Home - 1216 S. Charles St. Balto., Md.</b>		25a. REC'D BY REGISTRAR <b>FEB 23 1966</b>	
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

EXAMINER: This certificate must be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO DEPUTY MEDICAL EXAMINER: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH</p> <p>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p><b>CERTIFICATE OF DEATH</b></p> </div> <div> <p>01841</p> <p>01790</p> </div> </div>									
<p>1. PLACE OF DEATH</p> <p>a. COUNTY <b>Baltimore</b></p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mount Wilson</b></p> <p>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Mount Wilson State Hospital</b></p>					<p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</p> <p>a. STATE <b>MARYLAND</b> b. COUNTY <b>HOWARD</b></p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LAUREL</b></p> <p>d. STREET ADDRESS <b>WHISKEY BOTTOM ROAD</b></p> <p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>				
<p>3. NAME OF DECEASED (Type or print) <b>MARY AGNES CATHELL</b></p> <p>5. SEX <b>FEMALE</b></p> <p>6. COLOR OR RACE <b>WHITE</b></p> <p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p> <p>8. DATE OF BIRTH <b>1/13/92</b></p> <p>9. AGE (In years last birthday) <b>74</b> yrs.</p> <p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE KEEPER</b></p> <p>10b. KIND OF BUSINESS OR INDUSTRY <b>Mr. Ed. Kennedy</b></p> <p>11. BIRTHPLACE (County &amp; State, or foreign country) <b>BALTIMORE, Md.</b></p> <p>12. CITIZEN OF WHAT COUNTRY?</p>					<p>4. DATE OF DEATH <b>FEB. 1 1966</b></p> <p>13. FATHER'S NAME <b>ROBERT CATHELL</b></p> <p>14. MOTHER'S MAIDEN NAME <b>KATHERINE SHERIDAN</b></p> <p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b></p> <p>16. SOCIAL SECURITY NO. <b>213-36-1208</b></p> <p>17. INFORMANT Address <b>Hosp. records, Mt. Wilson St. Hospital</b></p>				
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CHRONIC INTERSTITIAL NEPHRITIS</b></p> <p>12X DUE TO</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO</p> <p>(c)</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>PULMONARY TUBERCULOSIS</b></p> <p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>									
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p> <p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p> <p>20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b></p> <p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></p> <p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p> <p>20f. (City or town) (County) (State)</p> <p>21. I certify that (I) (this hospital) attended the deceased from <b>6/21</b>, 1965, to <b>2/1</b>, 1966, that (I) (we) last saw the deceased alive on <b>2/1</b>, 1966, and that death occurred at <b>12:45</b> M, from the causes and on the date stated above.</p> <p>22a. SIGNATURE <b>Wm. Newcomer</b></p> <p>22b. DATE SIGNED <b>2/1/66</b></p> <p>22c. PHYSICIAN'S NAME (Type) <b>Wm. Newcomer, M.D., Superintendent</b></p> <p>22d. ADDRESS <b>Mount Wilson, Maryland</b></p>									
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b></p> <p>23b. DATE THEREOF <b>2/5/66</b></p> <p>23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b></p> <p>23d. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b></p> <p>24. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc. 3331 Brehms Lane</b></p> <p>25a. REC'D BY REGISTRAR <b>DATE 3 1966</b></p> <p>25b. REGISTRAR'S SIGNATURE</p>									

21 - 101

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VA AIS (4)  
ISM 9/59

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

01842

01791

1. PLACE OF DEATH a. COUNTY <b>Baltimore Co.</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Armco Nursing Home, 812 Register Ave.</b>				d. STREET ADDRESS <b>3834 Hickory Avenue</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>Anna B. Charlton</b>				4. DATE OF DEATH Month Day Year <b>February 21 19 66</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 5, 188</b>	9. AGE (In years lost birthday) yrs <b>85</b>	10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS Hours Min	12. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>George F. Laabes</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Gomps</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No N/A</b>				16. SOCIAL SECURITY NO. <b>No.</b>			
17. INFORMANT <b>Estelle Welsh</b>				Address <b>1316 Appleby Avenue</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma</b> <b>170 X</b> DUE TO <b>Carcinoma, Breast</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO (b) <b>24</b> (c) <b>24</b>							INTERVAL BETWEEN ONSET AND DEATH <b>24</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>12 9 1966</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>2/21 1966</b> to <b>2/21 1966</b> that (I) (we) last saw the deceased alive on <b>2/21 1966</b> , and that death occurred at <b>M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Charles F. O'Donnell</b>				22b. DATE SIGNED <b>2/21/66</b>			
22c. PHYSICIAN'S NAME (Type) <b>Charles F. O'Donnell, M.D.</b>				22d. ADDRESS <b>7501 York Road</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>Feb 25, 1966</b>			
23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>				23d. LOCATION (City, town, or county) (State) <b>Pikesville, Maryland</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Frank A. Leidy</b>				25a. REC'D BY REGISTRAR <b>FEB 24 1966</b>			
25b. REGISTRAR'S SIGNATURE <b>W. J. ...</b>							

M



FOR STATE HEALTH DEPT.

01843

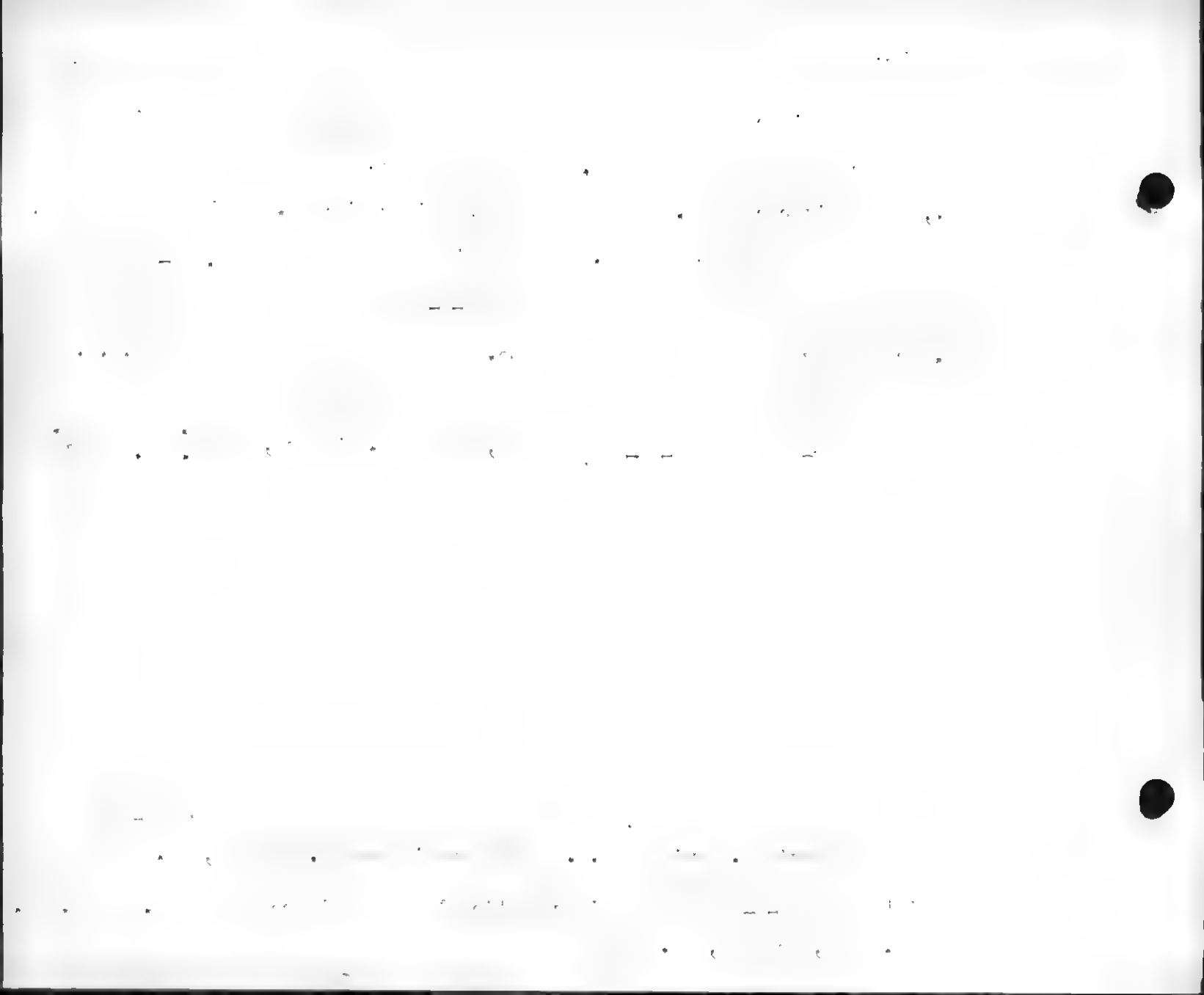
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01792

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 in the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Baltimore</b>	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Edgemore</b>		c LENGTH OF STAY IN TB <b>7 yrs.</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Res., 6927 Riverdrive Rd.</b>		e STREET ADDRESS <b>6927 Riverdrive Rd. 21219</b>	
3 NAME OF DECEASED (Type or print) <b>RUSSELL A. CHEEZUM</b>		4 DATE OF DEATH Month <b>Feb.</b> Day <b>28</b> Year <b>66</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Jan-3-1900</b>
9 AGE (In years last birthday) <b>66</b>		10 F UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>Ret. Crane Operator</b>		10b KIND OF BUSINESS OR EMPLOYER <b>Bethlehem Steel Co. Maryland</b>	
11 BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12 CITIZEN OF WHAT COUNTRY	
13 FATHER'S NAME <b>Charles Cheezum</b>		14 MOTHER'S MAIDEN NAME <b>Ann Bartlett</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes Navy WW I</b>		16 SOC. A. SECURITY NO. <b>213-07-6095</b>	
17 INFORMANT <b>Son, Ronald R. Cheezum, Balto. Md. 21231</b>		18a N. Castle St.	
18b CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cancer of Large Bowel</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>A-S-C-V Disease</b> (c) <b>DUE TO</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>M. B. Davis M.D.</b>		DATE SIGNED <b>March 1-1966</b>	
EXAMINER'S NAME (Type) <b>Molvin E. Davis M.D.</b>		6800 Mornington Rd. Dundalk, Md. 21222	
23a BURIAL, CREMATION, or other disposition	23b DATE THEREOF <b>Mar-3-1966</b>	23c NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>	23d LOCATION (City or Town) (County) (State) <b>5501 Frederick Ave. Balto. Md.</b>
24 FUNERAL DIRECTOR <b>JOHN J. DUDA, Dundalk, Md. 21222</b>		25a REC'D BY REG. STRAR DATE <b>MAR 3 1966</b>	
		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01844

## CERTIFICATE OF DEATH

01593

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b <b>47 days</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Dulaney Towson Nursing Home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				d. STREET ADDRESS <b>1603 Essex Farm Road</b>	
3. NAME OF DECEASED (Type or print) <b>Benoni J. Choin</b>		4. DATE OF DEATH Month <b>2</b> Day <b>28</b> Year <b>1966</b>		5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>July 12, 1877</b>		9. AGE (in years last birthday) <b>88 yrs.</b>		10. UNDER 1 YEAR Months <b>2</b> Days <b>28</b> Hours <b>19</b> Min. <b>66</b>		11. BIRTHPLACE (County & State, or foreign country) <b>France</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>LENOIR</b> <b>Alfred Choin</b>		14. MOTHER'S MAIDEN NAME <b>Beatrice VIRGINIA DESTHERIES</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Dulaney Towson Nursing Home, 111 W. St. Road</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Arteriosclerosis</b> (b) <b>3 hours.</b> (c) <b>3 hours.</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>Fell at home breaking h. femur. Bed rest since then</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>JAN 3 1966</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>BALTIMORE MD.</b>		21. I certify that (I) (this hospital) attended the deceased from <b>September, 1965</b> , to <b>February 1966</b> , that (I) (we) last saw the deceased alive on <b>2-28-1966</b> , and that death occurred at <b>6:40 M.</b> from the causes and on the date stated above.	
22a. SIGNATURE <b>Keith A. Manley</b>		22b. DATE SIGNED <b>3-1-66</b>		22c. PHYSICIAN'S NAME (Type) <b>KEITH A. MANLEY</b>		22d. ADDRESS <b>2045 YORK RD TOWSON MD 21093</b>		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>March 4, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Elmwood Park Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Chicago, Illinois</b>		24. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Towson</b>	
25a. REC'D BY REGISTRAR DATE <b>MAR 3 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. ADDRESS <b>1050 York Rd.</b>		25d. ADDRESS <b>1050 York Rd.</b>		25e. ADDRESS <b>1050 York Rd.</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

01845

01794

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u> c. LENGTH OF STAY IN IT <u>5 1/2 months</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bent Nursing Home</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>3604 W. Lexington St.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
<b>3. NAME OF DECEASED</b> (Type or print) <u>HATTIE</u>		<b>4. DATE OF DEATH</b> Last <u>CLARK</u> Month <u>2</u> Day <u>14</u> Year <u>1966</u>		<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>NOYRD</u>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>April 18 - 1888</u>		<b>9. AGE</b> (In years last birthday) <u>77</u> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.																			
Months	Days	Hours	Min.																		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>UNKNOWN</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Lake City, Gardia</u>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>USA</u>													
<b>13. FATHER'S NAME</b> <u>PRINCE C. LARK</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>EVERLYN BRANKLIN</u>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give year or dates of service)				<b>16. SOCIAL SECURITY NO.</b>				<b>17. INFORMANT</b> <u>Evelyn Branklin</u> Address <u>3604 W. Lexington St.</u>					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO <u>17</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO <u>Diabetes Mellitus</u> (c)												INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>years</u> <u>weeks</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)																<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)								<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)													
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)				<b>20f. (City or town)</b> (County) (State)									
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>October 26, 1965</u> <b>to</b> <u>February 14, 1966</u> <b>that (I) (we) last saw the deceased alive on</b> <u>February 14, 1966</u> <b>and that death occurred at</b> <u>1:55 PM</u> <b>from the causes and on the date stated above</b>																					
<b>22a. SIGNATURE</b> <u>Charles E. Williams</u> M.D.								<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>				<b>22b. DATE SIGNED</b> <u>February 14, 1966</u>									
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Reisterstown</u>								<b>22d. ADDRESS</b> <u>Mary Co.</u>													
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>2/19/66</u>				<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Crover Mem. Pk.</u>				<b>23d. LOCATION</b> (City, town or county) (State) <u>Laurel Md.</u>									
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>William S. Phillips</u>								<b>ADDRESS</b> <u>1727 N. Maple St.</u>				<b>25a. REC'D BY REGISTRAR</b> <b>25b. REGISTRAR'S SIGNATURE</b> <u>DATE FEB 23 1966</u> <u>William S. Judge</u>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

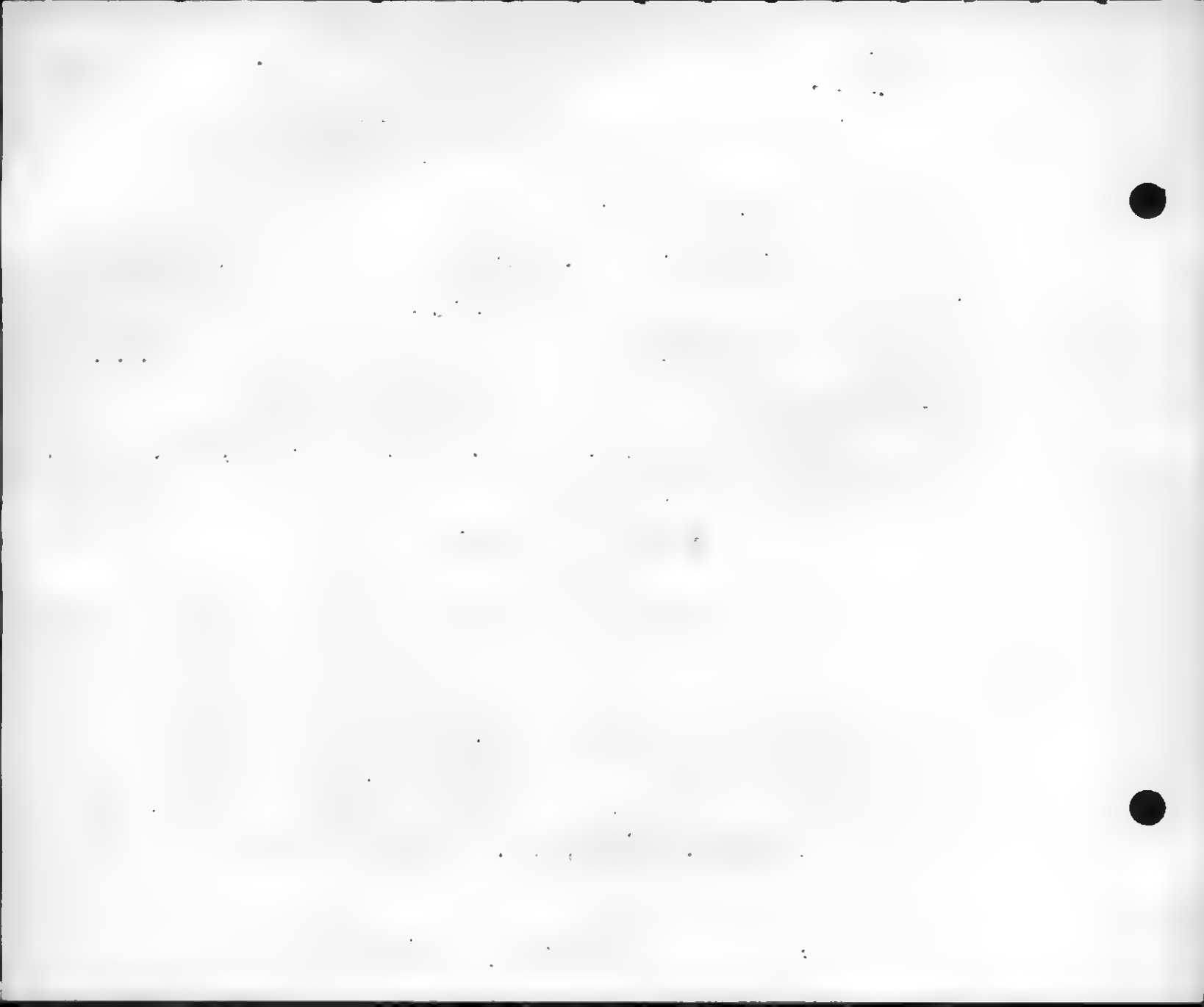


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

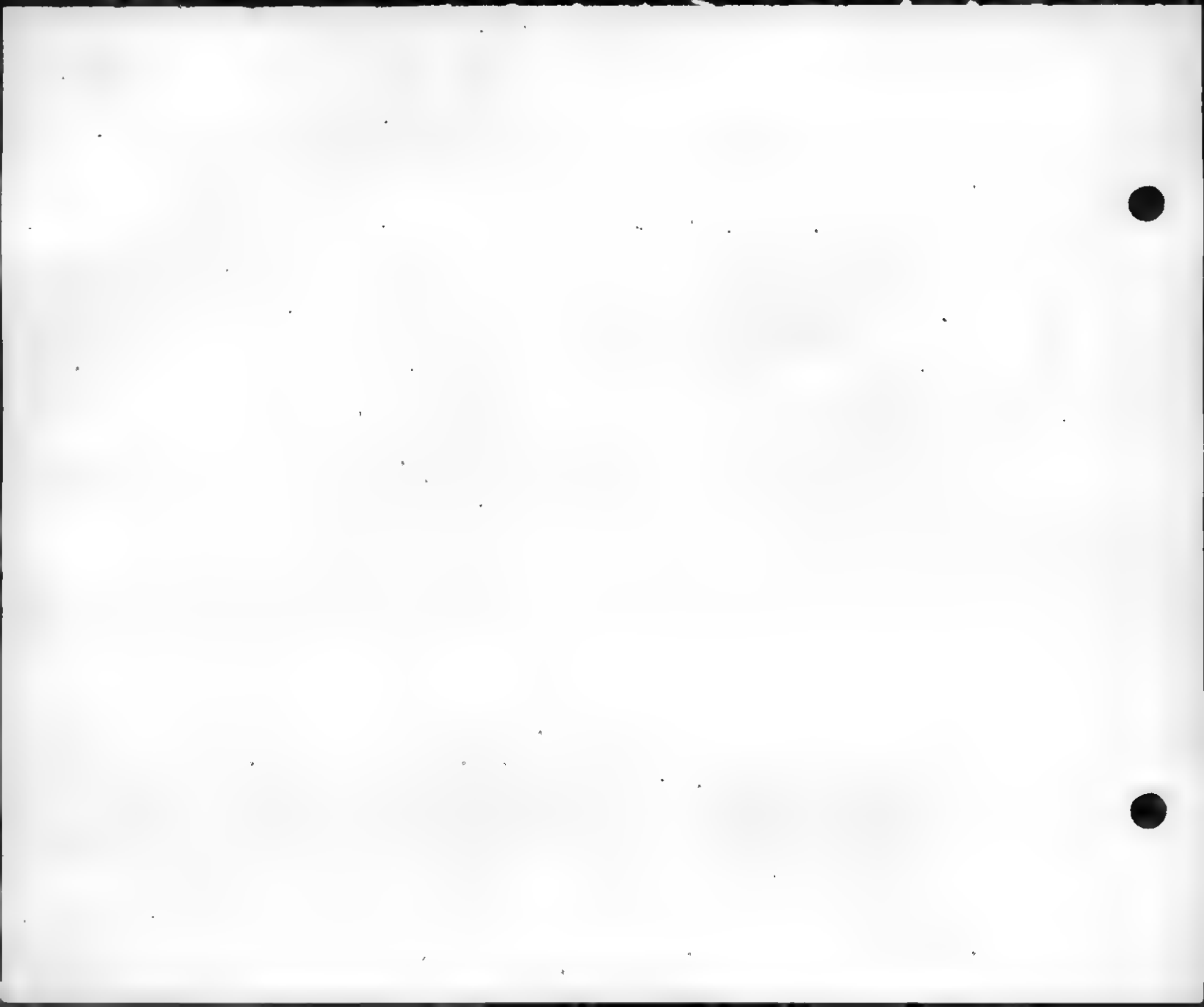
<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>									
<b>1. PLACE OF DEATH</b> a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b> c. LENGTH OF STAY IN 1b <b>10 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>					<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>WEST RIVER</b> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
<b>3. NAME OF DECEASED</b> (Type or print) First <b>SUMMERFIELD</b> Middle <b>C.</b> Last <b>CLAYTOR</b>					<b>4. DATE OF DEATH</b> Month <b>FEBRUARY</b> Day <b>14</b> Year <b>1966</b>				
<b>5. SEX</b> <b>MALE</b>		<b>6. COLOR OR RACE</b> <b>WHITE</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>MAY 31, 1889</b>		<b>9. AGE</b> (In years last birthday) <b>76</b> yrs. IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HRS.: _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>ATTENDANT</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>HOSPITAL</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>WEST RIVER, MARYLAND</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>WILLIAM CLAYTOR</b>					<b>14. MOTHER'S MAIDEN NAME</b> <b>MAGGIE LUCILLE CHEW</b>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW I</b>				<b>16. SOCIAL SECURITY NO.</b> <b>214 05 0870</b>		<b>17. INFORMANT</b> Address <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a) PULMONARY EDEMA</b> DUE TO <b>ACUTE MYELOID LEUKEMIA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>								<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>RECENT</b> <b>7 MONTHS</b>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that</b> <del>the</del> (this hospital) attended the deceased from <b>2/4/66</b> , 19____, to <b>2/14/66</b> , 19____, that <del>the</del> (we) last saw the deceased alive on <b>2/14/66</b> , 19____, and that death occurred at <b>6:25 PM</b> , from the causes and on the date stated above.									
<b>22a. SIGNATURE</b> <i>Paulino D. Deocampo</i>					<b>22b. DATE SIGNED</b> <b>2/15/66</b>		<b>22c. PHYSICIAN'S NAME</b> (Type) <b>PAULINO D. DEOCAMPO, M. D.</b>		
<b>22d. ADDRESS</b> <b>VAH FORT HOWARD, MARYLAND</b>									
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>BURIAL</b>		<b>23b. DATE THEREOF</b> <b>2-16-66</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Christ Church</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>Owensville Md.</b>			
<b>24. FUNERAL DIRECTOR</b> <b>Bernard Hardesty</b>					<b>25a. REC'D BY REGISTRAR</b> <b>BERNARD HARDESTY FUNERAL DIRECTOR</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <i>John Charles Judge</i>		
<b>25c. ADDRESS</b> <b>CALESVILLE, MARYLAND</b>					<b>DATE</b> <b>FEB 18 1966</b>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please move carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b <u>1</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>Baltimore</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>St. Joseph Hospital</u>						d. STREET ADDRESS <u>909 Rappaix Court</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Clay</u> Middle <u>F.</u> Last <u>Coard</u>		4. DATE OF DEATH Month <u>February</u> Day <u>27</u> Year <u>1966</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-16-78</u>	
9. AGE (in years last birthday) <u>87</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Lemont, Virginia</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>Maintenance</u>		13. FATHER'S NAME <u>Thomas Esley Coard</u>			
14. MOTHER'S MAIDEN NAME <u>Lelia M. Kellam</u>						15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-12-0855</u>		17. INFORMANT <u>Charles T. Coard</u> Address <u>(Same)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of larynx</u> <u>16ix</u> DUE TO (b) <u>Bronchopneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Emphysema</u>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>p.m.</u> <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 18</u> , 19 <u>66</u> , to <u>Feb. 27</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Feb. 27</u> 19 <u>66</u> , and that death occurred at <u>4 P.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>D.R. Govinda Rao</u> M.D.						22b. DATE SIGNED <u>2-28-66</u>		22c. PHYSICIAN'S NAME (Type) <u>D. R. Govinda Rao, M.D.</u>		22d. ADDRESS <u>7620 York Rd., Baltimore, Md. 21204</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/2/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Park</u>		23d. LOCATION (City, town or county) (State) <u>Parkville, Balto. Co. Md.</u>		24. FUNERAL DIRECTOR <u>H.W. Jenkins &amp; Sons Co.</u>		25a. REC'D BY REGISTRAR <u>4905 York Road Balto. 12, Md.</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>MAR 1 1966</u>									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
01848 CERTIFICATE OF DEATH 01797

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>25 Gwynn Lake Drive</u>				d. STREET ADDRESS <u>25 Gwynn Lake Drive 7</u>			
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>L.</u> Last <u>Cockey</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>9</u> Year <u>1966</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/11/1886</u>	
9. AGE (in years last birthday) <u>79</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME <u>John T. Birnie</u>			
14. MOTHER'S MAIDEN NAME <u>Jane ?</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u>			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>Mrs. Charles Birnie same address as above</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardio Vascular Disease</u> DUE TO (b) DUE TO (c) CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Mar. 22, 1957</u> to <u>Feb 9, 1966</u> , that (I) (we) last saw the deceased alive on <u>Feb-8, 1966</u> , and that death occurred at <u>9:30 AM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Harry L. Kniff, M.D.</u>				22b. DATE SIGNED <u>2-9-66</u>		22c. PHYSICIAN'S NAME (Type) <u>HARRY L. KNIFF, M.D.</u>	
22d. ADDRESS <u>446 Edmondson Ave. Balt 29 Md.</u>				22e. REC'D BY REGISTRAR			
22f. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				22g. DATE <u>FEB 14 1966</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/12/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Wootton Park Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR <u>Wm. F. Tichner &amp; Sons</u>				24a. ADDRESS <u>Baltimore, Md.</u>			

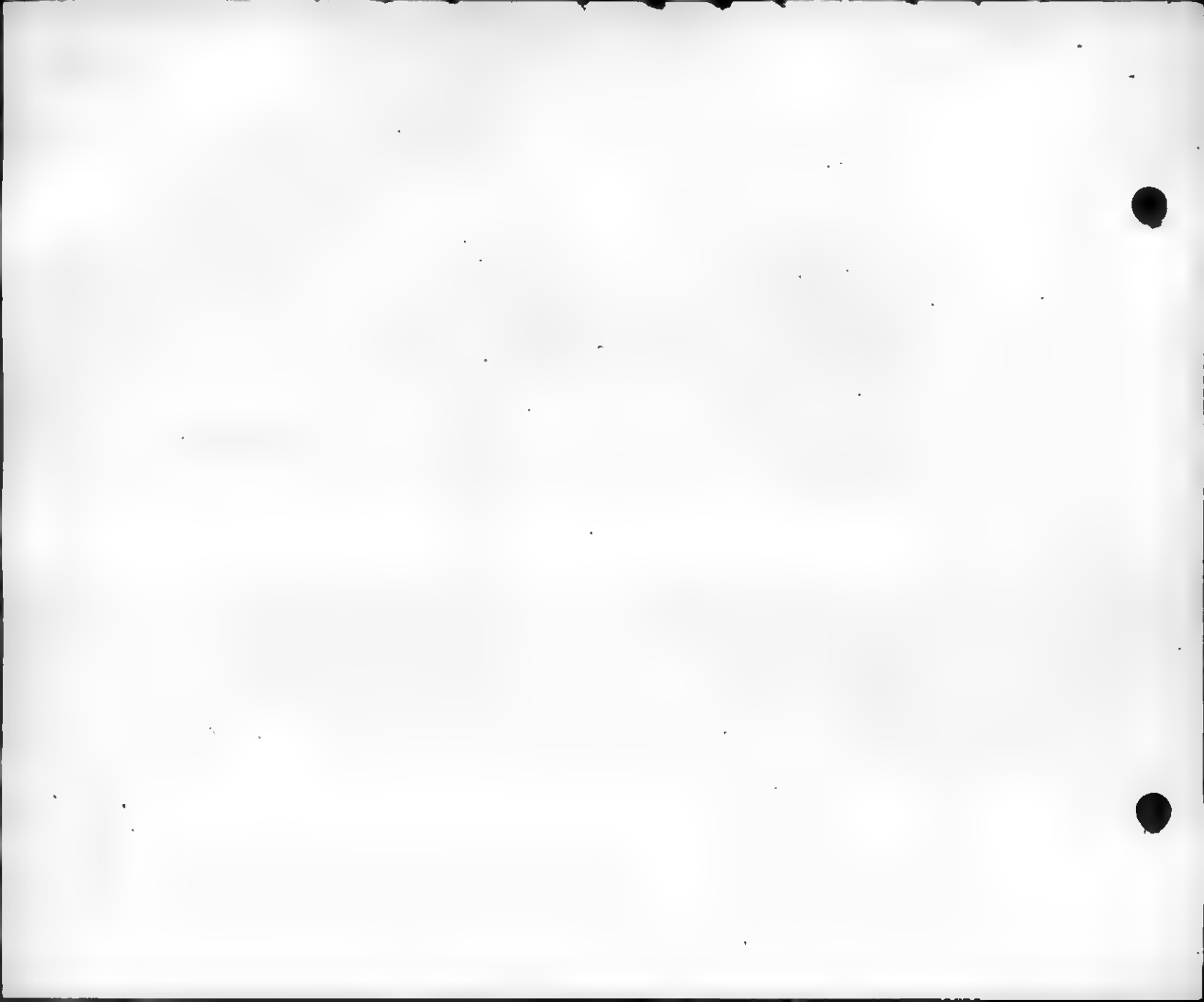


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
01849		01798									
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u> c. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Baltimore County Gen. Hosp.</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>21st</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>6716 Brighton Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Berbert</u> Middle <u>I.</u> Last <u>Cohan</u>						4. DATE OF DEATH Month <u>Feb.</u> Day <u>14</u> Year <u>1966</u>					
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/21/1902</u>		9. AGE (in years last birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>3</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>EMPLOYEE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>SOCIAL SECURITY ADM.</u>				11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE MARYLAND</u>			
13. FATHER'S NAME <u>LOUIS COHAN</u>						14. MOTHER'S MAIDEN NAME <u>MARY D. ?</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes give war or dates of service) <u>WW 1</u>						16. SOCIAL SECURITY NO. <u>215-03-8821</u>					
17. INFORMANT <u>MRS. RENA COHEN</u>						Address <u>6716 BRIGHTON AVE</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of stomach</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Bludging b. tract</u> DUE TO (c) <u>Lymphoma</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 28</u> , 19 <u>66</u> , to <u>Feb. 14</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Feb. 14</u> , 19 <u>66</u> , and that death occurred at <u>11 P</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>L. B. Lerma</u>						22b. DATE SIGNED <u>2-15-66</u>					
22c. PHYSICIAN'S NAME (Type) <u>L. B. Lerma</u>						22d. ADDRESS <u>Baltimore County Gen. Hospital</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>2/16/66</u>				23c. NAME OF CEMETERY OR CREMATORY <u>HEBREW FRIENDSHIP</u>			
23d. LOCATION (City, town or county) (State) <u>BALTIMORE, MARYLAND</u>											
24. FUNERAL DIRECTOR <u>SOL LEVINSON &amp; BROS. INC. 6010 REISTERSTOWN RD</u>						25a. REC'D BY REGISTRAR <u>FEB 17 1966</u>					
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>											



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

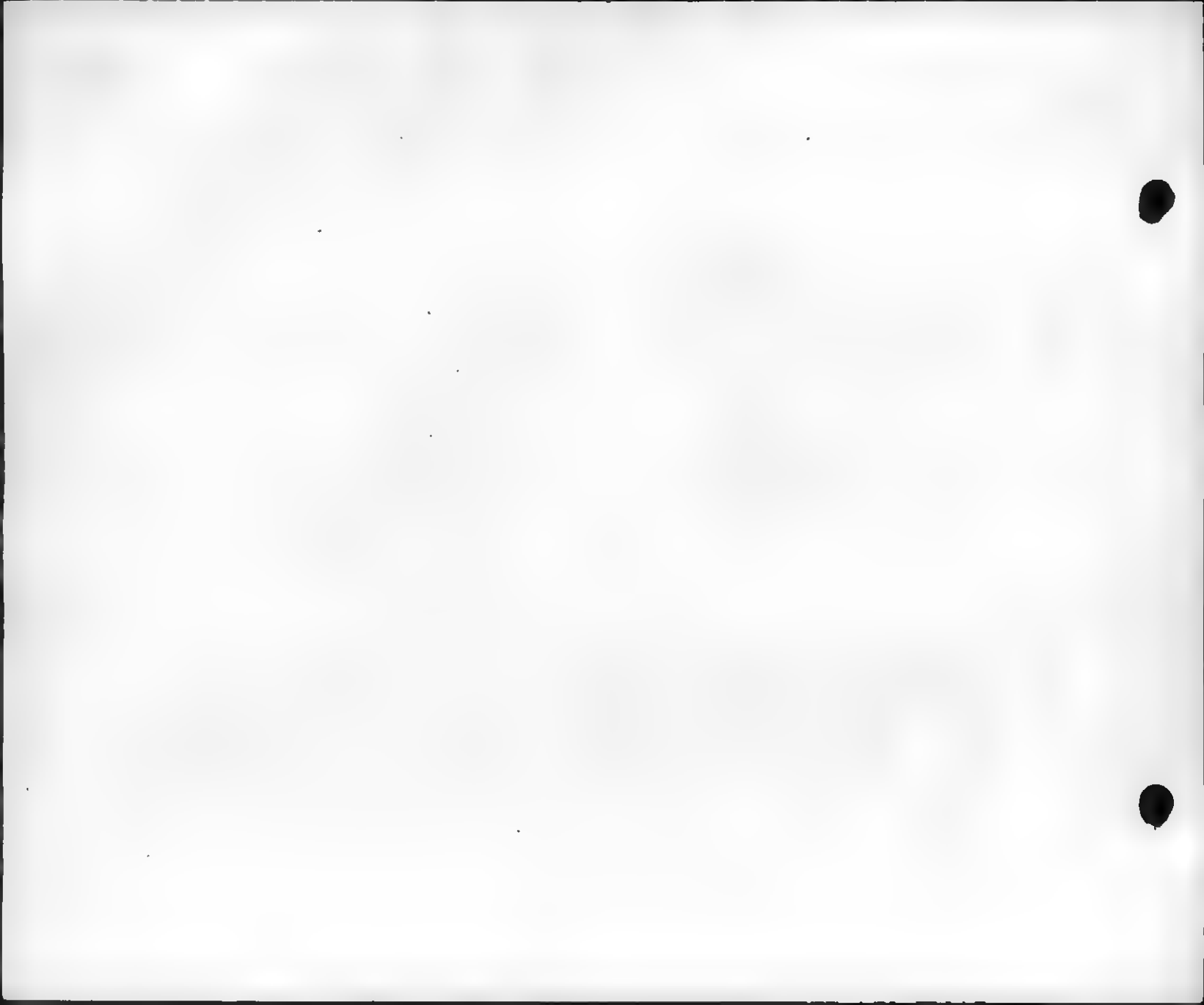
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01850

01799

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>(RURAL) SUNNYBROOK, PHOENIX P.O.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HUTZLER PARKING LOT DULANEY VA. Rd</u>				d. STREET ADDRESS <u>MERRYMAN'S MILL Rd.</u>		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>GEORGE R. CONKLIN, SR.</u>				4. DATE OF DEATH Month Day Year <u>2 - 7 1966</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-23-1888</u>	9. AGE (n years last birthday) <u>77</u> yrs	10. UNDER 1 YEAR Months Days Hours Min		11. UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED PROPRIETOR &amp; STORAGE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>TRANSFER</u>		11. BIRTHPLACE (State or foreign country) <u>BALTO. CO., MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WALTER H. CONKLIN</u>				14. MOTHER'S MAIDEN NAME <u>BARBARA BROWN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOC. A. SECURITY NO. <u>218-32-1950</u>		17. INFORMANT <u>WIFE</u> <u>MRS. BERTHA F. CONKLIN</u>		Address <u>SAME</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Insufficiency</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>5 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <u>Charles F. Donnell</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASS STANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <u>BALTO. CO., MD.</u>		22. DATE SIGNED <u>7/7/66</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2 - 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CHASTANT GROVE</u>		23d. LOCATION (City or Town) (County) (State) <u>BALTO. CO., MD.</u>	
24. FUNERAL DIRECTOR <u>J. Walter Conklin</u>		ADDRESS <u>5444 BELAIR Rd</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 14 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

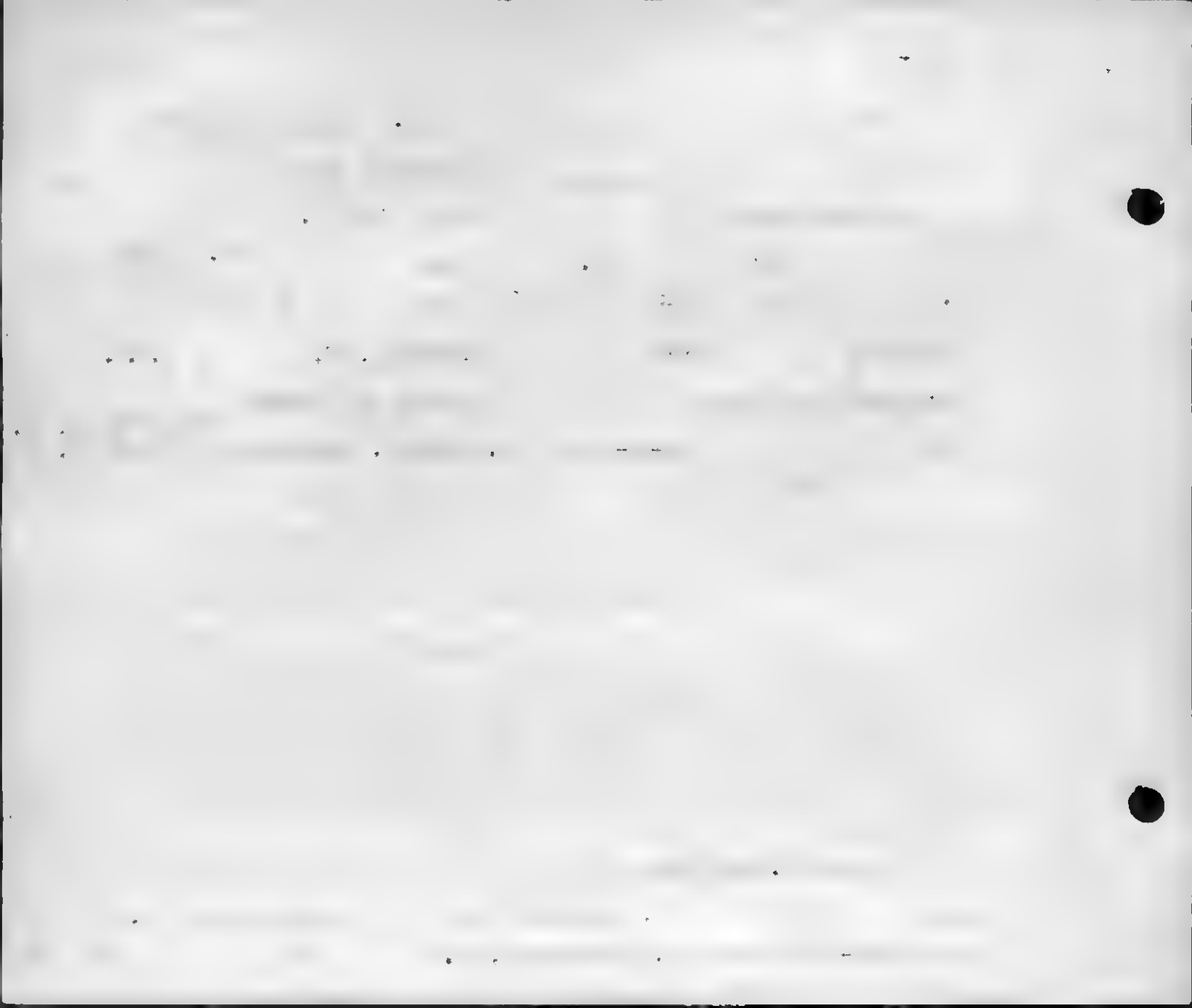
## CERTIFICATE OF DEATH

01851

01800

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore 21207</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Church Road Box 234</b>				d. STREET ADDRESS <b>3719 Milford Rd.</b>			
3. NAME OF DECEASED (Type or print) <b>Flora E. Cook</b>				4. DATE OF DEATH <b>Feb. 16, 1966</b>			
5. SEX <b>F.</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/22/1885</b>	
9. AGE (In years last birthday) <b>80</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min		10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of work ng life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Hebbville, Md.</b>	
13. FATHER'S NAME <b>George Washington Longley</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Ann Shotrow</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>220-34-5740</b>		17. INFORMANT <b>Mrs. Amelia E. Heiland-Box 234 Church Rd.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Atherosclerosis - generalized</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____				INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OF CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>October 1965</b> to <b>February 16, 1966</b> that (I) (we) last saw the deceased alive on <b>February 15, 1966</b> , and that death occurred at <b>2:00 A.M.</b> from the causes and on the date stated above.							
22. SIGNATURE <b>Clarence E. McWilliams</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>February 16, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Clarence E. McWilliams</b>				22d. ADDRESS <b>Reisterstown, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/19/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olive Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore 21207, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Loring Byers-8728 Liberty Rd. Randallstown, Md.</b>				25. REC'D BY REGISTRAR <b>FEB 21 1966</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

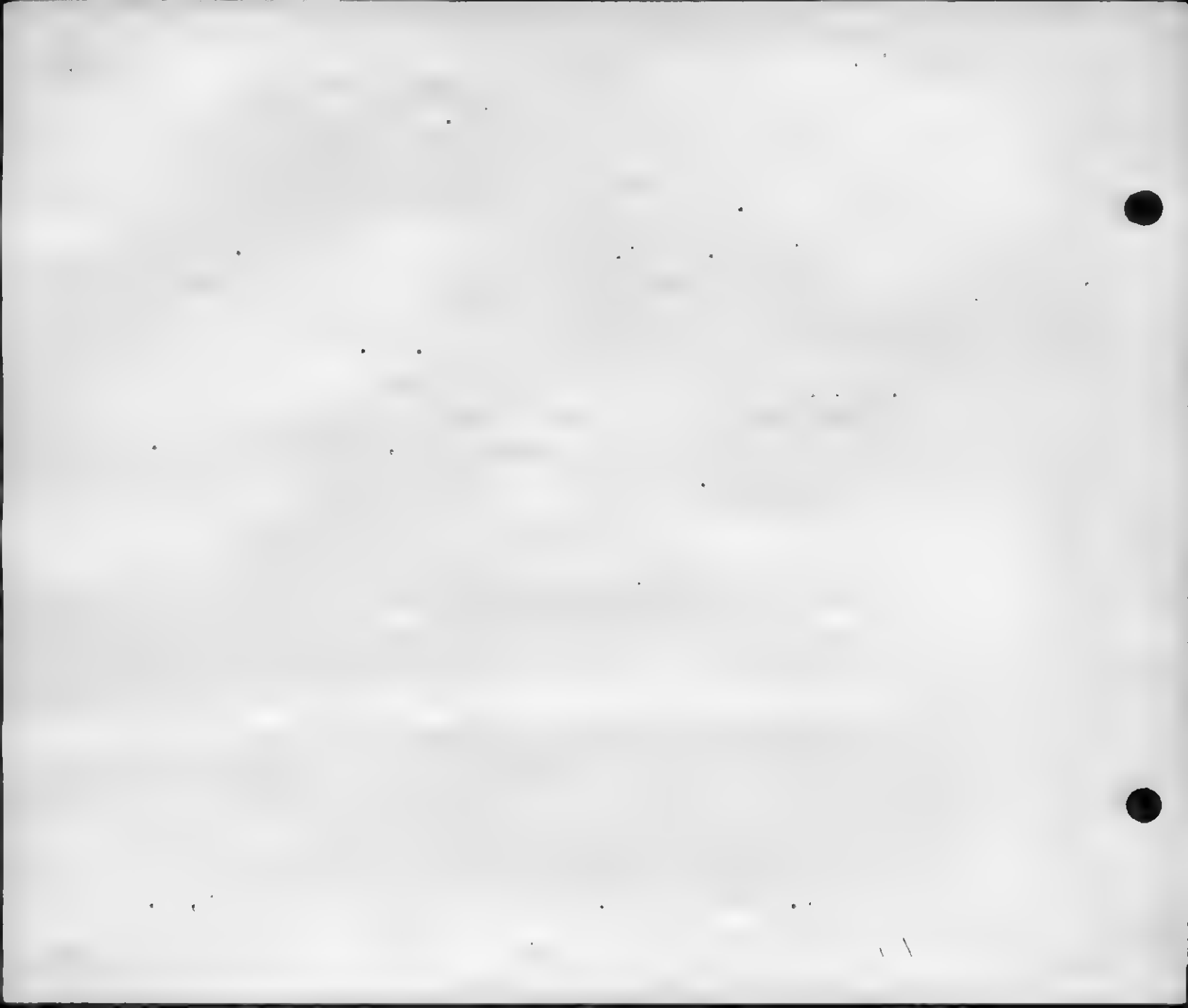


# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <span style="float: right;"><u>MARYLAND</u></span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN It d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>51 Briarwood Rd.</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) STATE <u>Md.</u> b. COUNTY <u>Balto.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville 28</u> d. STREET ADDRESS <u>51 Briarwood Road</u> • IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>William E. Costin</u> First Middle Last		<b>4. DATE OF DEATH</b> <u>Feb. 5/66</u> Day Month Year	
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>	
<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>May 9/ 89</u>	
<b>9. AGE</b> (In years last birthday) <u>76</u> yrs.		<b>10. IF UNDER 1 YEAR</b> Months Days	
<b>11. IF UNDER 24 HRS.</b> Hours Min.		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>	
<b>13. FATHER'S NAME</b> <u>G.B. Costin</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Unknown</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service)		<b>16. SOCIAL SECURITY NO.</b>	
<b>17. INFORMANT</b> <u>Emma Costin, 51 Briarwood Rd. zone 28</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary thrombosis</u> DUE TO (b) <u>Arterio sclerosis - general</u> DUE TO (c) <u>Senility.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>10 yrs.</u>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).</b>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>1935</u> <b>to</b> <u>2/5</u> <b>1966</b> , <b>that (I) (we) last saw the deceased alive on</b> <u>1/3/66</u> <b>and that death occurred at</b> <u>10:5 AM</u> <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>A Calas</u>		<b>22b. DATE SIGNED</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>A CALAS</u>		<b>22d. ADDRESS</b> <u>6411 Frederick Ave.</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>Feb. 8/66</u>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Loudon Park</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Baltimore 29, Md.</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Witzke F. D.</u>		<b>25a. REC'D BY REGISTRAR</b>	
<b>25b. REGISTRAR'S SIGNATURE</b> <u>4101 Edmondson Ave</u>		<b>DATE</b> <u>EB 7 1966</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1 (M)  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

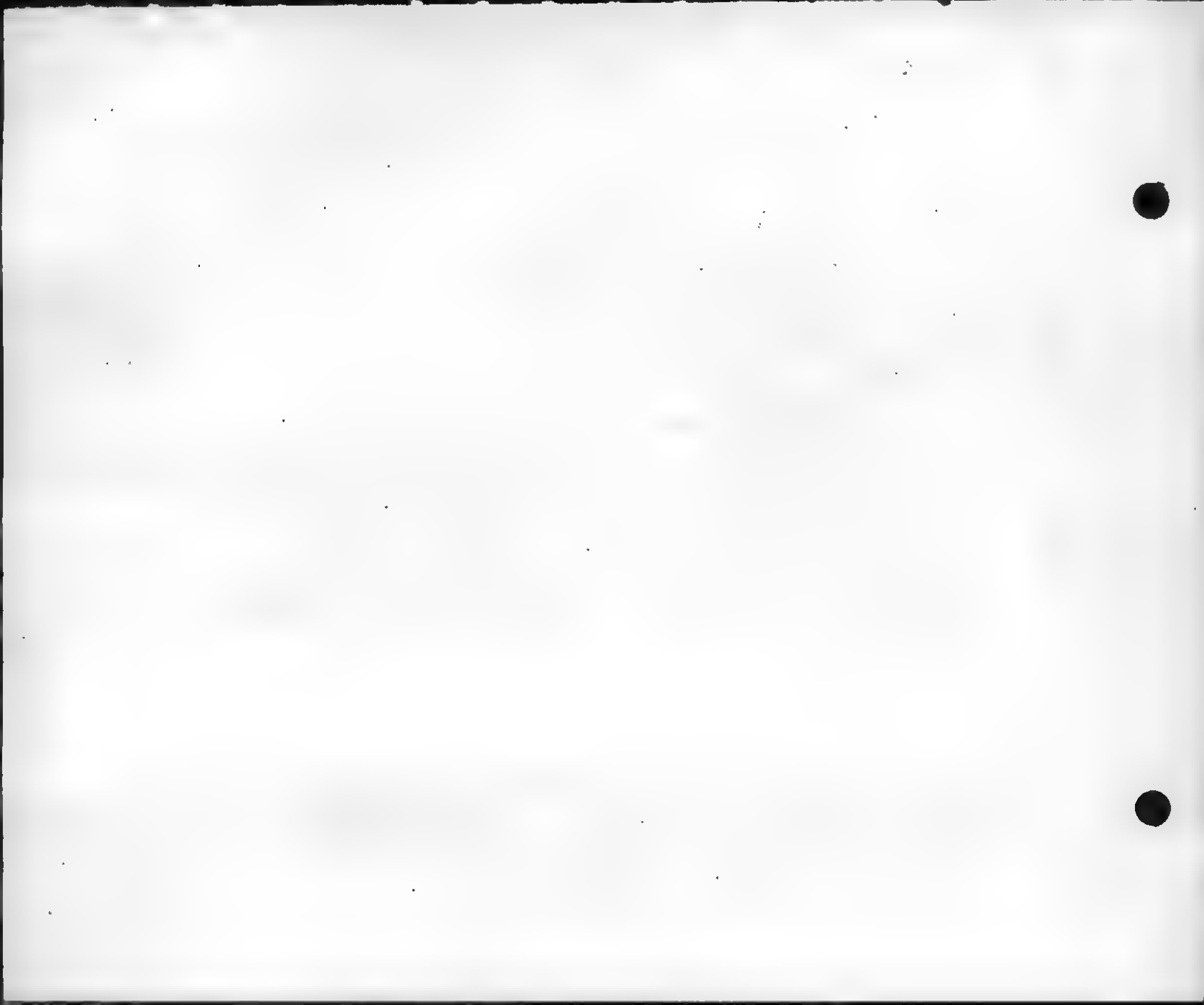
01853

01802

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>MARYLAND</b> COUNTY <b>BALTO</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTO - RURAL</b>		c. LENGTH OF STAY IN 1b <b>12 yrs</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>417 ELMWOOD Ave</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>THOMAS HENRY CUMMINGS</b>		4. DATE OF DEATH Month <b>Feb</b> Day <b>3</b> Year <b>1966</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 5 - 1897</b>
9. AGE (In years last birthday) <b>68 yrs.</b>		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>8</b>	11. IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Superintendent</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Crown Cork Seal</b>	11. BIRTHPLACE (State or foreign country) <b>Tillmans Island</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Charles Cummings</b>	
14. MOTHER'S MAIDEN NAME <b>Alice S. Sinclair</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT <b>Mrs Frances Cummings 417 Elmwood Road</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ATHEROSCLEROTIC Cardio -</b> <b>4221</b> DUE TO <b>Vascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Emphysema</b>			INTERVAL BETWEEN ONSET AND DEATH <b>sevr.</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>	
22. DATE SIGNED <b>2-3-66</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	
23b. DATE THEREOF <b>2-7-1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Cemetery</b>	
23d. LOCATION (City, town or county) (State) <b>Dogwood Road Baltimore Co.</b>		24. FUNERAL DIRECTOR <b>Lanark Funeral Home 74 W. Baker Road</b>	
25a. REC'D BY REGISTRAR <b>5-6-7 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

### CERTIFICATE OF DEATH

01854

01803

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Balto.</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>St. Joseph's Nursing Home</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>✓</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>226 Stonecroft Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF</b> (Type or print) <u>Gilbert J. Dailey</u>		<b>4. DATE OF DEATH</b> Month <u>Feb.</u> Day <u>2</u> Year <u>1966</u>	
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Feb. 12/77</u>
<b>9. AGE</b> (In years last birthday) <u>88</u>		<b>10. IF UNDER 1 YEAR</b> Months <u>8</u> Days <u>19</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Retired</u>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Balto. Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>Dailey</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Unknown</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown)		<b>16. SOCIAL SECURITY NO.</b> <u>212 10 7416</u>	
<b>17. INFORMANT</b> <u>Maurice L. Dailey</u>		<b>Address</b> <u>226 Stonecroft Rd</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State)
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>1945</u> <b>to</b> <u>2/2</u> , 19 <u>66</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>2/1</u> 19 <u>66</u> , <b>and that death occurred at</b> <u>1:50</u> P.M., <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>Thos E Roach</u>		<b>22b. DATE SIGNED</b> <u>2/4/66</u>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Thos E Roach</u>		<b>22d. ADDRESS</b> <u>5530 B220 Nard Pine 21228 Md</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>Feb. 5/66</u>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>New Cathedral</u>		<b>23d. LOCATION (City, town or county)</b> (State) <u>Balto. Md.</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Witzke F.D.</u>		<b>25a. REC'D BY REGISTRAR</b> <u>7</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>1966</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

1804

01855

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<b>Baltimore</b>		<b>Maryland</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Box 10 Maine Avenue</b>		d. STREET ADDRESS <b>Box 10 Maine Avenue zone 19</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Feliksa</b> Middle <b>Danielczyk</b> Last		4. DATE OF DEATH Month <b>2</b> - Day <b>23</b> Year <b>19 66</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 30 1887</b>
9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>	
11. BIRTHPLACE (State or foreign country) <b>Poland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A.</b>	
13. FATHER'S NAME <b>Carol Binkowski</b>		14. MOTHER'S MAIDEN NAME <b>Catherin Idamowski</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>217129940</b>	
17. INFORMANT <b>Mrs Helen Michalski</b>		Address <b>Box 10 Maine Ave-I9</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocarditis</b> <b>Chronic</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Influenza</b> (c) <b>Terminal Bronch-Pneumonia</b>			INTERVAL BETWEEN ONSET AND DEATH <b>15 days</b> <b>8 days</b> <b>48 hrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Feb 15 1966</b> to <b>Feb 23 1966</b> , that I last saw the deceased alive on <b>Feb 23 1966</b> , and that death occurred at <b>4:15 P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>6800 Morning Lane</b> DATE SIGNED <b>2/24/66</b>			
ACTUAL SIGNATURE <b>M B DAVIS</b>		M.D. <b>Walter Dabrowski</b>	
PHYSICIAN'S NAME (Type) <b>M B DAVIS M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2-28-66</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Holy Rosary Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Dabrowski 1005 Dundalk Ave.</b>		24a. REC'D BY REGISTRAR DATE <b>2-28-66</b>	24b. REGISTRAR'S SIGNATURE

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

TO DEPUTY CHIEF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

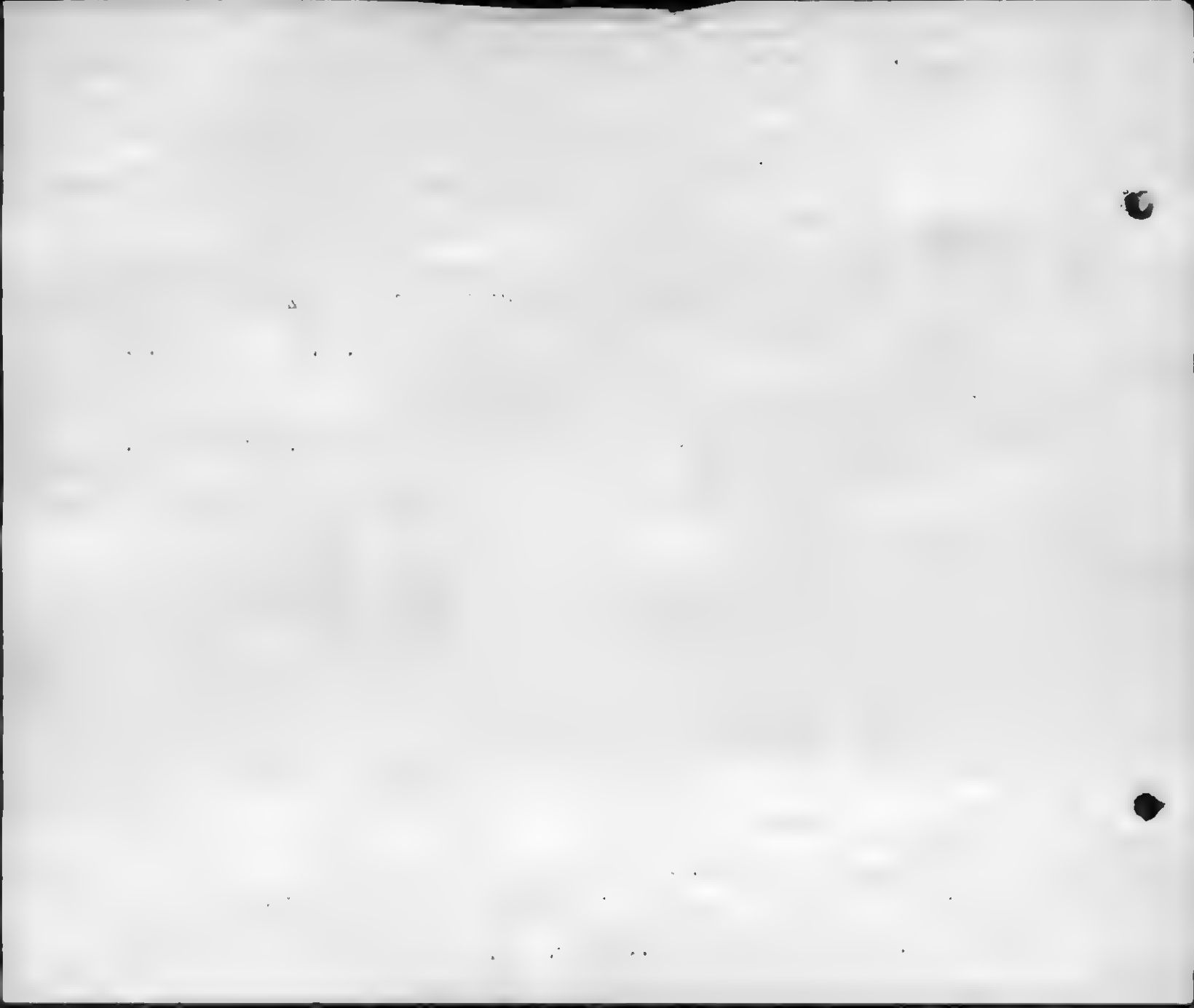
Item 1 421 File 337 MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

01856

01805

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore-rural</b>		c. LENGTH OF STAY IN lb <b>Baltimore</b>	
2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
3. NAME OF DECEASED (Type or print) <b>Clifton William Davenport</b>		d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Fort Howard Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
4. SEX <b>male</b>	5. COLOR OR RACE <b>colored</b>	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	7. WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 13, 1911</b>	9. AGE (In years last birthday) <b>54</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Porter</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>	
13. FATHER'S NAME <b>Joseph Davenport</b>		14. MOTHER'S MAIDEN NAME <b>Martha Lomax</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. <b>116-03-7384</b>		17. INFORMANT <b>Emma Davenport - 900 W. Lexington St.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive spontaneous intra-cerebral hemorrhage</b> 351X DUE TO (b) Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last, DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)					INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Baltimore</b>		20g. (County) <b>Baltimore</b>		20h. (State) <b>Maryland</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>2/15/66</b> Address (Street city town, or county) <b>Baltimore, Maryland</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-18-66</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>	
22d. LOCATION (City town, or county) <b>Baltimore, Maryland</b>		22e. (State) <b>Maryland</b>			
23. FUNERAL DIRECTOR <b>Charles R. Law</b>		ADDRESS <b>802 Madison Ave., Balto., Md.</b>		24a. REC'D BY REG. STRAR <b>FEB 18 1966</b>	
24b. REGISTRAR'S SIGNATURE <b>Charles R. Law</b>					

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in ~~any~~ <sup>any</sup> event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

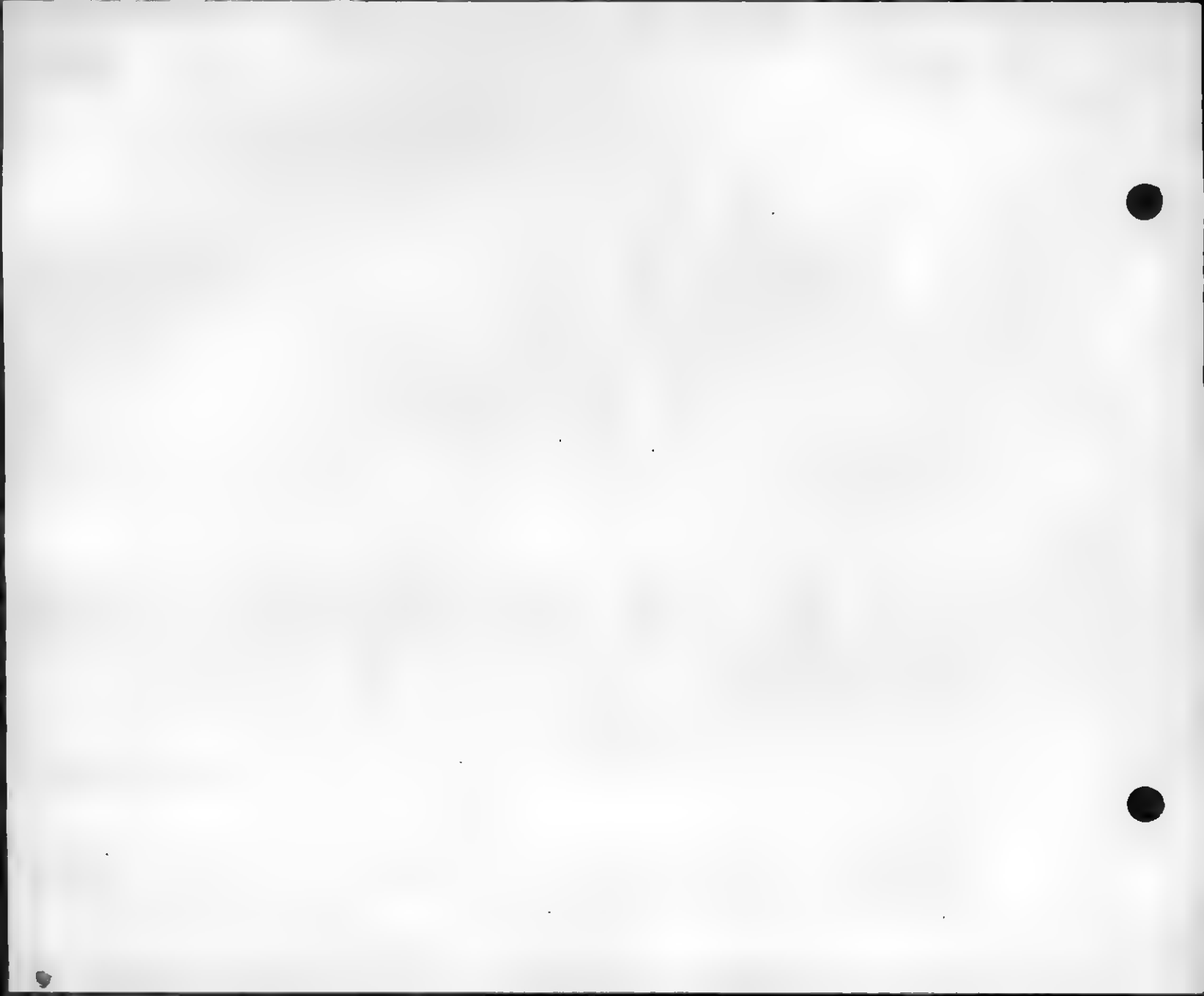
01857

## CERTIFICATE OF DEATH

01806

Item #11 Film #0-73 2/21/66

1. PLACE OF DEATH e. COUNTY <b>BALTO.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>BALTO</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>17 PARK DRIVE</b>		d. STREET ADDRESS <b>17 PARK DRIVE</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>CHARLES WESLEY DAVIS</b>		4. DATE OF DEATH Month Day Year <b>FEB 11 1966</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG. 16, 1882</b>
9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SUN PAPERS RT. OWNER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MD</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>MD</b>	
13. FATHER'S NAME <b>THOMAS W. DAVIS</b>		14. MOTHER'S MAIDEN NAME <b>SUSIE DELOSIER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>220 446 389</b>	
17. INFORMANT <b>C. ETHEL DAVIS</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Stroke</b> DUE TO (b) <b>retrograde cerebral aneurysm</b> DUE TO (c) <b>hypertension</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Aug 25, 19</b> to <b>Feb 11</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>Jan 11</b> 19 <b>66</b> , and that death occurred at <b>12:45</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>John A. MacNabb</b>		22b. DATE SIGNED <b>2-12-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN A. MACNABB</b>		22d. ADDRESS <b>301 FREDK. RD. 21228</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>FEB 14, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>WESTERN</b>		23d. LOCATION (City, town or county) (State) <b>BALTO. MD</b>	
24. FUNERAL DIRECTOR <b>F. S. MACNABB</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>FEB 14 1966</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

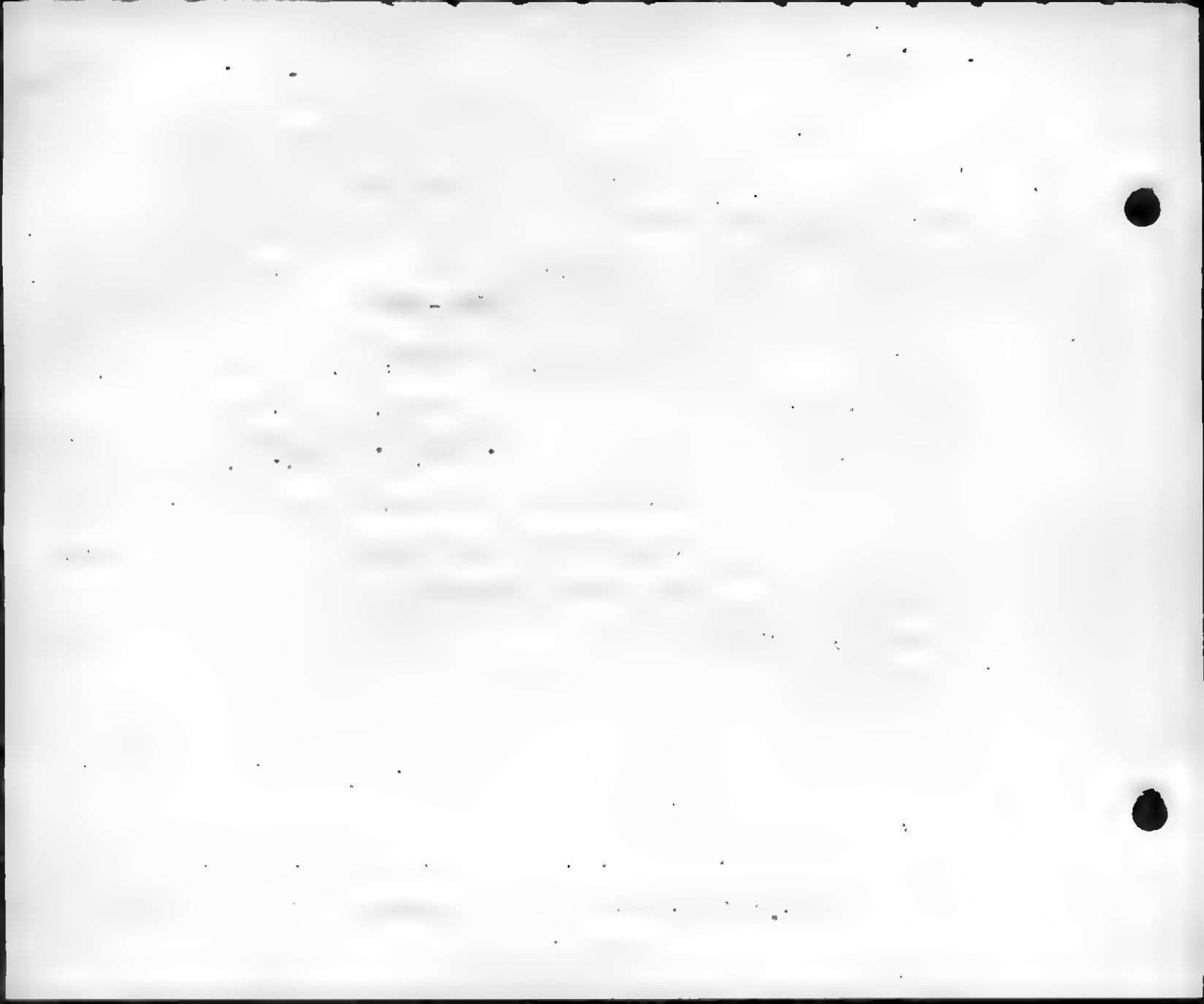
VR A15 (4)  
2DM 1/65

M

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b> c. LENGTH OF STAY IN 1b <b>4 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <b>MARYLAND</b> f. COUNTY <b>WICOMICO</b> g. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SALISBURY</b> h. STREET ADDRESS <b>221 MIDDLE BLVD.</b> i. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>EDWARD</b> Last <b>DAVIS</b>		4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>18</b> Year <b>19 66</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>XXXX-XXXX-12-18-98</b>
9. AGE (In years last birthday) <b>67</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RUBBER HOSE CO.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>WILLARDS WORCESTER CO., MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>BENJAMIN T. DAVIS</b>		14. MOTHER'S MAIDEN NAME <b>ANNA K. DAVIS DAVIS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW-11</b>		16. SOCIAL SECURITY NO. <b>217 10 3691</b>	
17. INDEMNITY <b>Mr. Louis F. Davis (Son) Same as #2 Above</b>		18. CLIN. REC., VET. ADM. HOSP. FT HOWARD, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY EDEMA AND CONGESTIVE CARDIAC FAILURE</b> DUE TO (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> (c) <b>OLD MYOCARDIAL INFARCTION</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 YEAR</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>PYODERMA, GENERALIZED</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>e.m.</b> <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Feb. 14 2:00 19 66</b> , to <b>Feb. 18 19 66</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Feb. 18, 1966</b> , and that death occurred at <b>a. M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Walter M. Stern</b>		22b. DATE SIGNED <b>2-18-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>WALTER M. STERN, M. D.</b>		22d. ADDRESS <b>VET. ADM. HOSP., FT. HOWARD, MARYLAND</b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>Feb. 22/1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Dennis Family Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>WILLIARDS, MARYLAND</b>
24. FUNERAL DIRECTOR <b>HOLLOWAY &amp; COMPANY</b>		25. REGISTRAR'S SIGNATURE <b>FEB 23 1966</b>	
ADDRESS <b>SALISBURY, MARYLAND</b>		DATE	

MEDICAL CERTIFICATION



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01808

FOR STATE HEALTH DEPT.

01859

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural- Baltimore</b> c. LENGTH OF STAY IN b <b>Rural- Baltimore</b>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <b>Md.</b> b COUNTY <b>Baltimore</b> c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural- Baltimore</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>1310 Medmeadow Rd.</b>		d STREET ADDRESS <b>1310 Midmeadow Rd.</b> e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>Charles Kirby Dawson</b> First Middle Last		4 DATE OF DEATH <b>Feb. 2</b> Month Day Year <b>19 66.</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Nov. 13, 1899.</b>
9 AGE (In years last birthday) yrs <b>66</b>		10 IF UNDER 1 YEAR Months Days Hours Min <b>66</b>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>		10b KIND OF BUSINESS OR INDUSTRY <b>Electrical</b>	
11 BIRTHPLACE (State or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY <b>USA</b>	
13 FATHER'S NAME <b>Charles K. Dawson</b>		14 MOTHER'S MAIDEN NAME <b>Catherine Kirk</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service)		16 SOCIAL SECURITY NO <b>714-01-7316</b>	
17 INFORMANT <b>Mrs. Eva C. Dawson,</b> Address <b>(Same)</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY <b>772x</b> IMMEDIATE CAUSE (a) <b>Gunshot (32 Cal. Pistol)</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Wound of Head</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Charles F O'Donnell</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>2/2/66</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b DATE THEREOF <b>1/5/66</b>	23c NAME OF CEMETERY OR CREMATORY <b>WOODLAWN CEMETERY</b>	23d LOCATION (City or town) (County) (State) <b>BALTIMORE, MD</b>
24 FUNERAL DIRECTOR <b>Leonard J. Ruck Inc. Balto. Md. 21214</b>		25a REC'D BY REGISTRAR <b>FEB 4 1966</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

MARYLAND STATE DEPARTMENT OF HEALTH

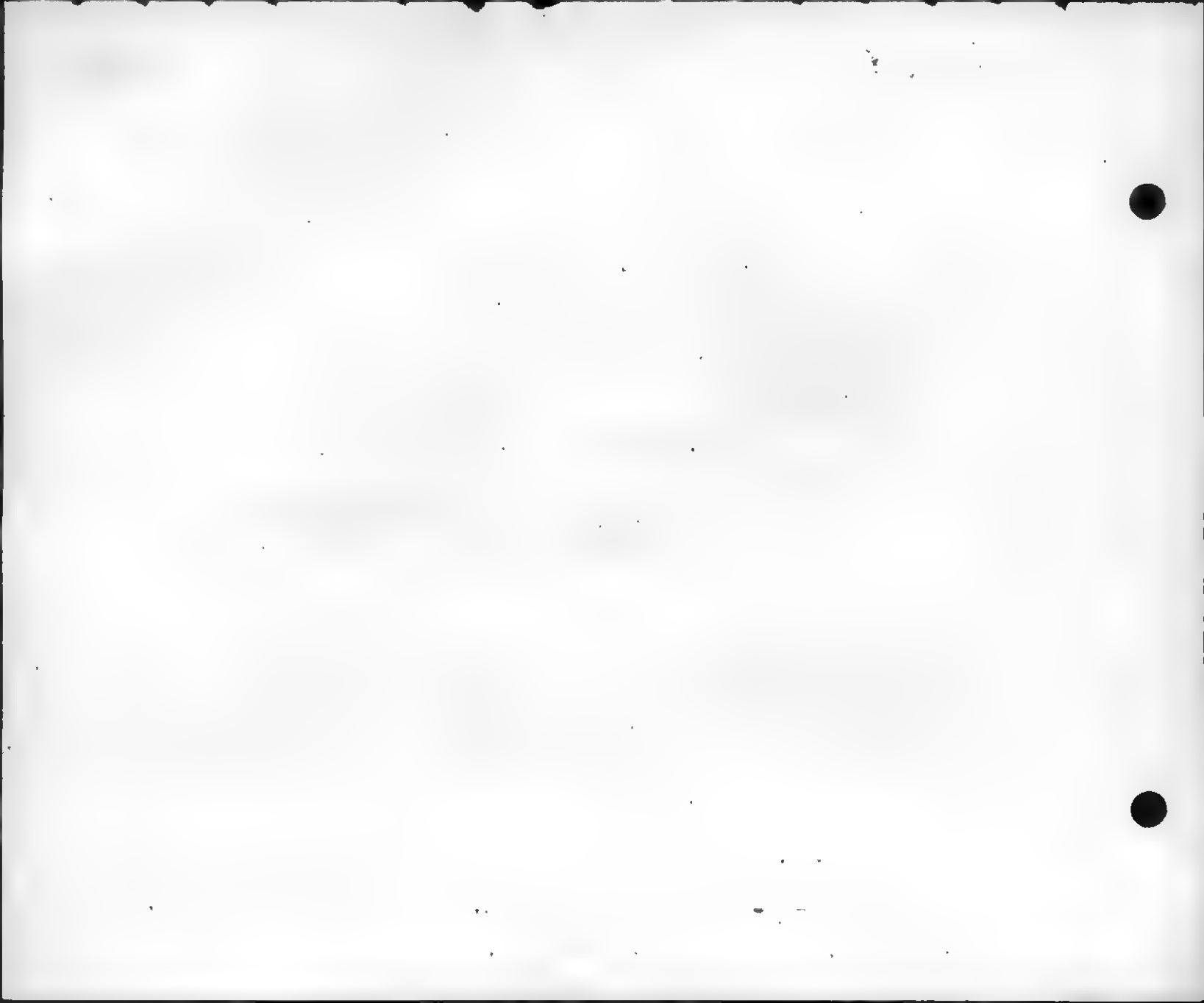
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01860

01809

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>✓</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>St. Joseph's Hospital</u>				e. STREET ADDRESS <u>3213 Westfield Avenue</u>			
3. NAME OF DECEASED (Type or print) <u>John L. deBeaumont</u>				4. DATE OF DEATH <u>February, 19 19 66</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 12, 1903</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plant Supervisor</u>		11. BIRTHPLACE (County & State, or foreign country) <u>C &amp; P Telephone Co. Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John deBeaumont</u>				14. MOTHER'S MAJOREN NAME <u>Hannah Doyle</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212050448</u>		17. INFORMANT <u>Sally deBeaumont</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of right lung with metastasis to liver and lymph nodes</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Confluent bronchopneumonia, left lower lobe</u> DUE TO (c) <u>NO</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 16</u> , 1966, to <u>Feb. 19</u> , 1966, that (I) (we) last saw the deceased alive on <u>February 19, 1966</u> , and that death occurred at <u>10:15</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>				M.O. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>February 19, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>D. R. Govinda Rao</u>				22d. ADDRESS <u>7620 York Road, 21204</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>2-23-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Morleand Mem. Park</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc Baltimore, Md.</u>				25a. RECEIVED BY REGISTRAR <u>FEB 23 1966</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.



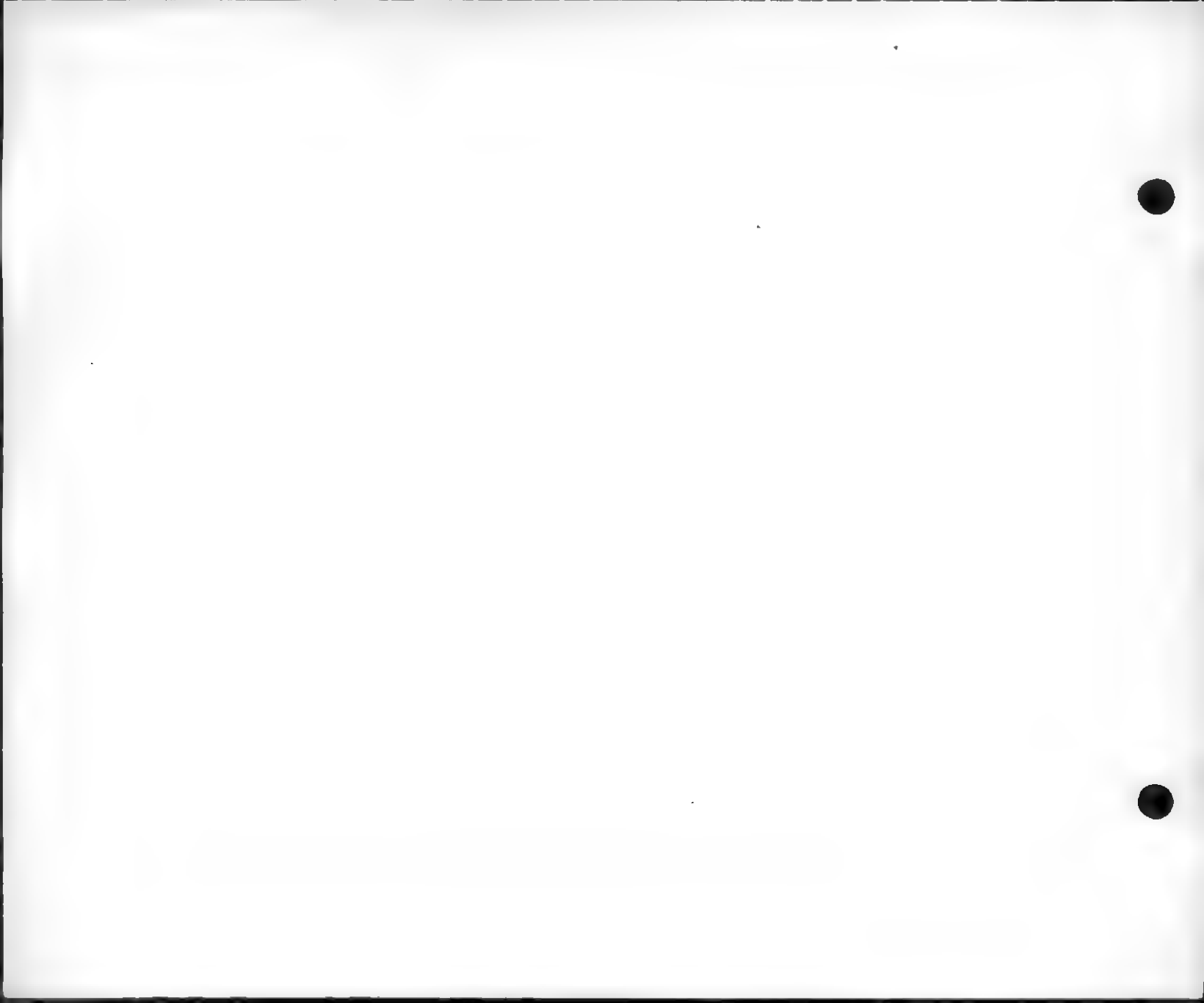
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01861

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01810

1 PLACE OF DEATH a COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Baltimore</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c LENGTH OF STAY N 1b <b>Towson</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>936 Dulaney Valley Road</b>		d STREET ADDRESS <b>936 Dulaney Valley Road</b>	
3. NAME OF DECEASED (Type or print) First <b>ANITA</b> Middle <b>FISCHER</b> Last <b>DECKER</b>		4 DATE OF DEATH Month <b>February</b> Day <b>27</b> Year <b>1966</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B DATE OF BIRTH <b>Sept. 5, 1899</b>
9 AGE (In years last birthday) yrs <b>66</b>		IF UNDER 1 YEAR Months <b>6</b> Days <b>6</b> Hours <b>6</b> Min <b>6</b>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11 BIRTHPLACE (State or foreign country) <b>Wisconsin</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>Arthur P. Fischer</b>		14 MOTHER'S MAIDEN NAME <b>Olga Michaels</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates at service) <b>NO</b>		16 SOCIAL SECURITY NO <b>218-14-0431</b>	
17 INFORMANT <b>FAMILY RECORDS</b>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pulmonary thrombosis with infarction of left lower lobe</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>4651</b> (c) <b>4651</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Neurogenic bladder</b>			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day Year Hour a.m. <b>19</b> p.m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)		20f (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Russell S. Fisher</b> M.D.		22. DATE SIGNED <b>2-28-66</b>	
EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b>		Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>	23b DATE THEREOF <b>3/1/66</b>	23c NAME OF CEMETERY OR CREMATORY <b>Greenmount</b>	23d LOCATION (City or town) (County) (State) <b>Balto. City Md.</b>
24 FUNERAL DIRECTOR <b>John Angus Lois</b>		25a REC'D BY REGISTRAR <b>Chapman, Ted</b>	
25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>MAR 3 1966</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

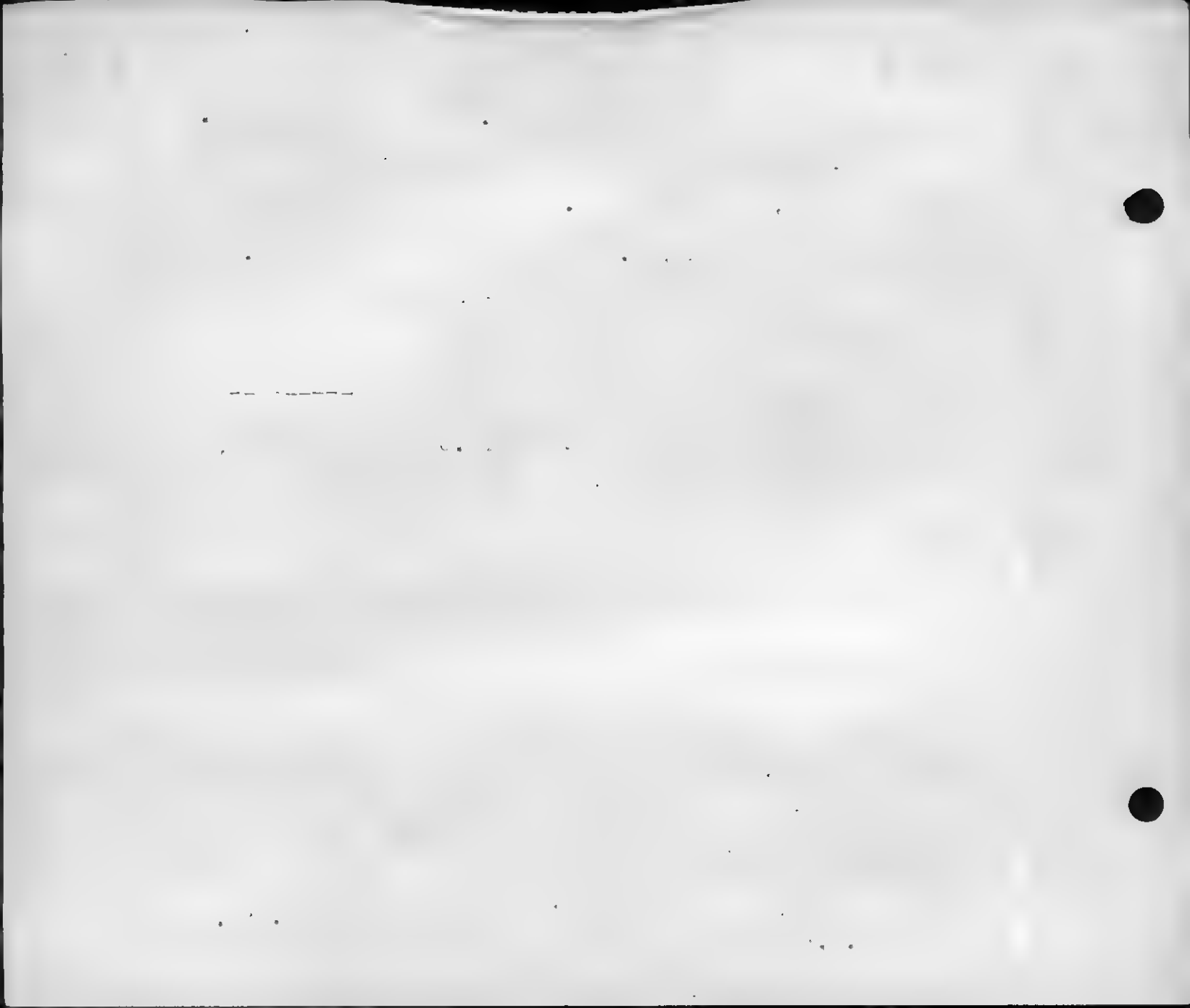
## CERTIFICATE OF DEATH

01862

01811

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>House In Pines, 16 Fusting Ave.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Balto</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> d. STREET ADDRESS <b>308 Lee Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Frank (Francesco) P. De Fina</b> First Middle Last		4. DATE OF DEATH <b>Feb. 10/66</b> Month Day Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 9/82</b> yrs. Months Days
9. AGE (in years last birthday) <b>83</b> yrs. Months Days		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Presser</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Italy</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph DeFina</b>		14. MOTHER'S MAIDEN NAME <b>Catherine</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>412 03 4629</b>	
17. INFORMANT <b>Mrs. Carmela DeFina</b>		Address <b>Zone 28</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the stomach</b> 151X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Feb 9</b> 1966, to <b>Feb 10</b> 1966 that (I) (we) last saw the deceased alive on <b>Feb 9</b> 1966, and that death occurred at <b>6 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Justina S. Kudirka</b> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>JUSTINA S. KUDIRKA</b>		22d. ADDRESS <b>Bethelton Rd, Sympsonville Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>2/14/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>	23d. LOCATION (City, town or county) (State) <b>Balto. Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke F.D. 4101 Edmondson Ave</b>		25a. REC'D BY REGISTRAR <b>FEB 15 1966</b> DATE	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in a separate envelope within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01863

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

01812

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN 1b <b>5 Yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Forest Haven Nursing Home</b>				2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> d. STREET ADDRESS <b>1322 Dillon Heights Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Catherine E. Delker</b>			4. DATE OF DEATH <b>Feb. 17, 1966</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Apr. 17, 1878</b>	9. AGE (In years last birthday) <b>87 yrs.</b>	IF UNDER 1 YEAR: Months <b>8</b> Days <b>17</b> Hours <b>15</b> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Md.</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>John Delker</b>				
14. MOTHER'S MAIDEN NAME <b>Catherine Schlag</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				
16. SOCIAL SECURITY NO. <b>None</b>			17. INFORMANT <b>Raymond L. Clingman</b> Address <b>1322 Dillon Hghts/A</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident</b> DUE TO (b) <b>Generalized Arteriosclerosis</b> DUE TO (c) <b>15+ years</b>					INTERVAL BETWEEN ONSET AND DEATH <b>6+ months</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year <b>19</b>					
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>12/20, 1960</b> , to <b>17 Feb, 1966</b> , that (I) (we) last saw the deceased alive on <b>2 Feb 1966</b> , and that death occurred at <b>3:35 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Wm. Gallagher, Jr.</b>				22b. DATE SIGNED <b>18 Feb 66</b>			
22c. PHYSICIAN'S NAME (Type) <b>Wilmer K. Gallagher, Jr.</b>				22d. ADDRESS <b>6630 Balto. National Pike</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-19-1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ward's Chapel</b>			
23d. LOCATION (City, town or county) (State) <b>Baltimore Co. Md.</b>		24. FUNERAL DIRECTOR <b>Howard Strong</b> ADDRESS <b>3707 W. North Ave.</b>					
25a. REC'D BY REGISTRAR <b>FEB 21 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>					

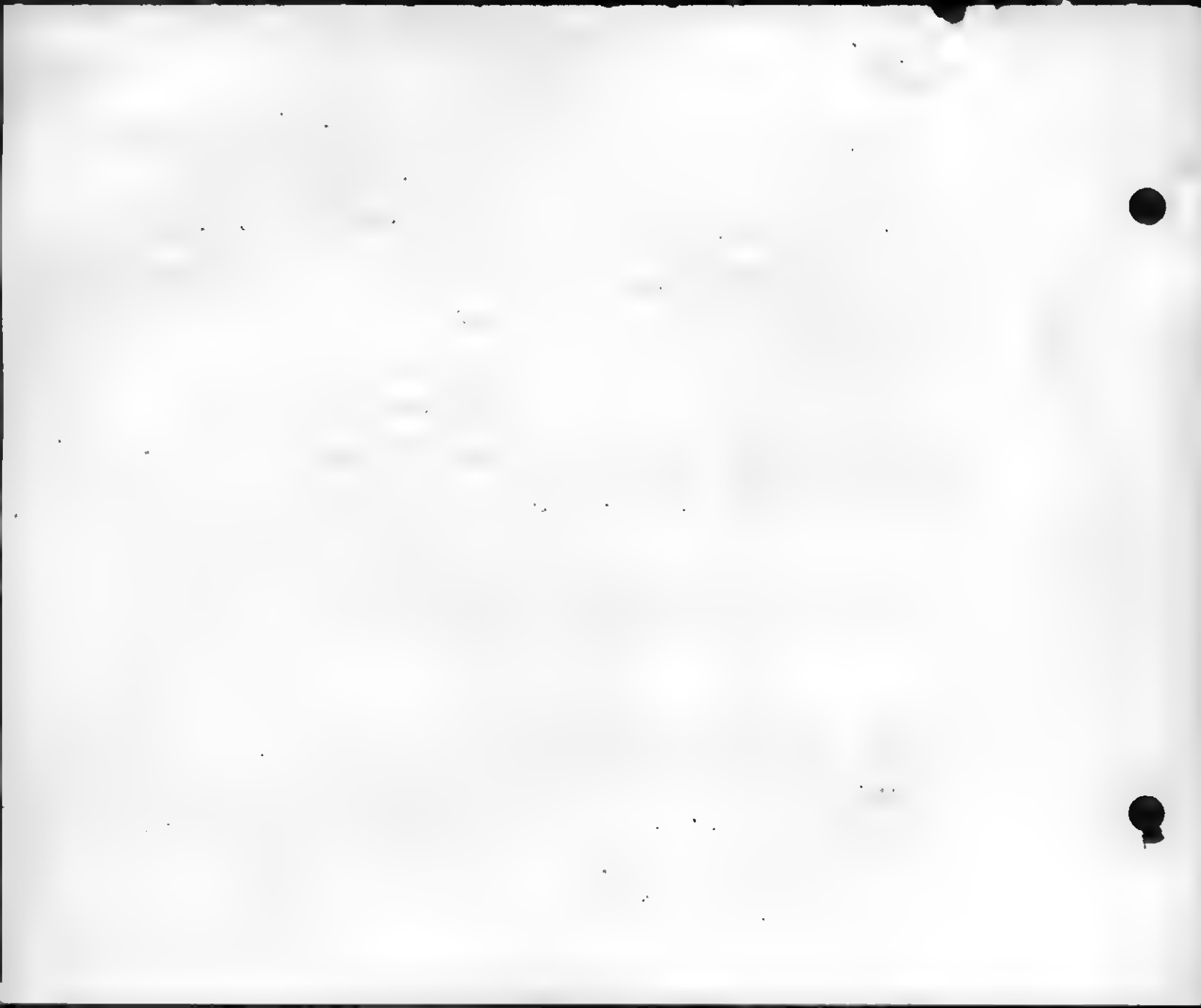


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, within 72 hours after death.

VR A15 (4)  
20M 1/65

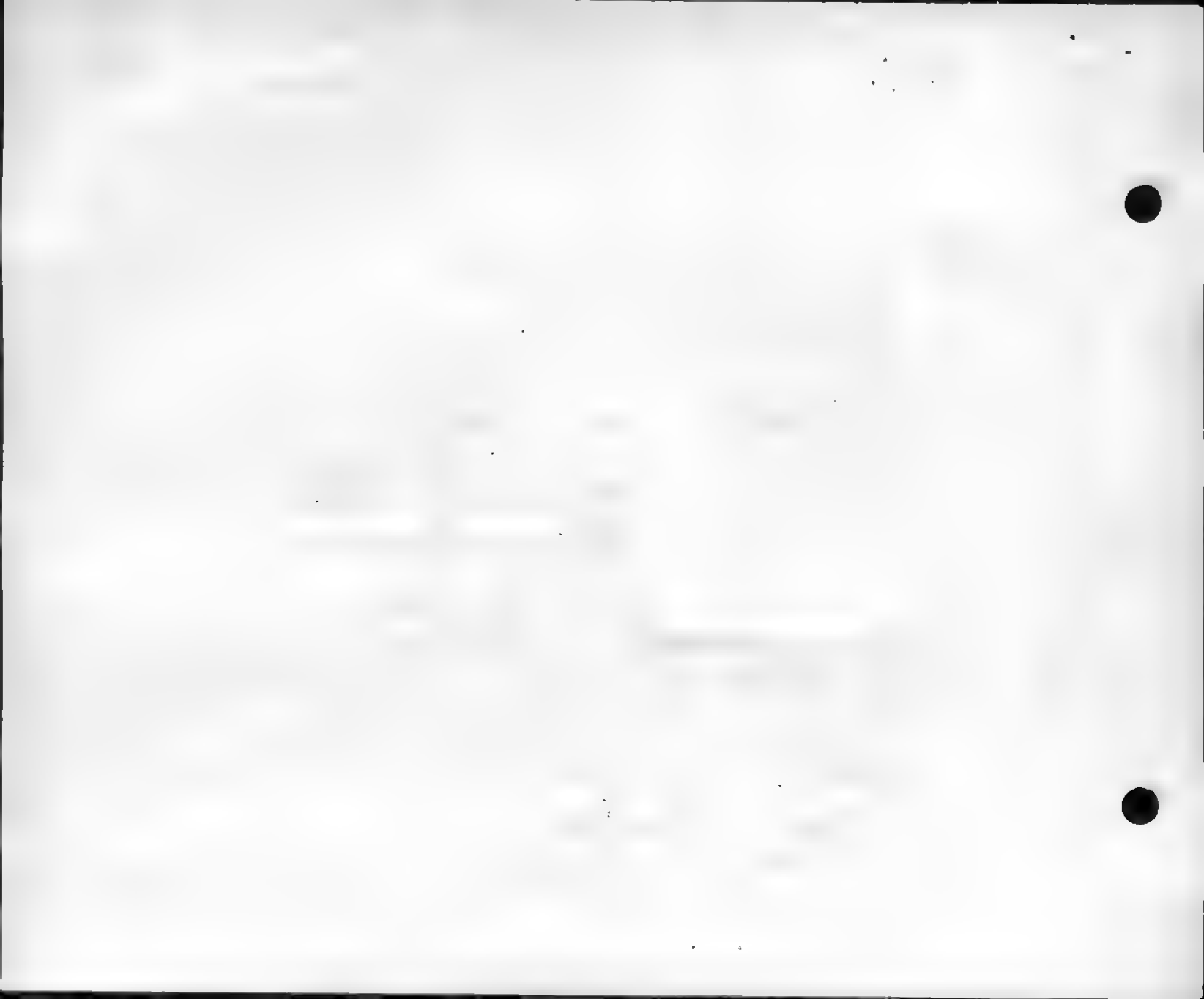
<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>																				
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u> c. LENGTH OF STAY IN ID _____ d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>St. Joseph Hospital</u>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Baltimore</u></span> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>7929 Elmhurst Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
<b>3. NAME OF DECEASED</b> (Type or print) <u>John N. Denk</u>			<b>4. DATE OF DEATH</b> Month <u>February</u> Day <u>13</u> Year <u>1966</u>			<b>5. SEX</b> <u>Male</u>			<b>6. COLOR OR RACE</b> <u>White</u>			<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDDED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>			<b>8. DATE OF BIRTH</b> <u>2-27-22</u>			<b>9. AGE</b> (In years last birthday) <u>43</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HRS. _____		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Construction</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Cogswell Constr.</u>						<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Baltimore, Maryland</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> _____														
<b>13. FATHER'S NAME</b> <u>John A. DENK</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>MARY Faustich</u>														
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>Yes</u> (If give war or dates of service) <u>WW II</u>				<b>16. SOCIAL SECURITY NO.</b> <u>212 16 9013</u>				<b>17. INFORMANT</b> <u>Anna M. Denk</u> Address <u>7929 Elmhurst Ave</u>												
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____												<b>INTERVAL BETWEEN ONSET AND DEATH</b> _____								
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.) _____ <b>20c. TIME OF INJURY</b> Month, Day, Year _____ Hour a.m. _____ p.m. <u>19</u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____ <b>20f. (City or town) (County) (State)</b> _____																				
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>1-29</u> , 19 <u>66</u> , to <u>2-13</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2-13</u> , 19 <u>66</u> , and that death occurred at <u>2:10</u> M, from the causes and on the date stated above.																				
<b>22a. SIGNATURE</b> <u>Licerio Cerna</u>												<b>22b. DATE SIGNED</b> <u>Feb. 13, 1966</u>								
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Licerio Cerna, M. D.</u>												<b>22d. ADDRESS</b> <u>7620 York Rd. 21204</u>								
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>2-16-66</u>				<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Gardens of Faith Cemetery</u>				<b>23d. LOCATION (City, town or county) (State)</b> <u>Baltimore Md.</u>								
<b>24. FUNERAL DIRECTOR</b> <u>Thelma F. Coach</u> <u>1211 Chesaco Ave.</u>												<b>25a. REC'D BY REGISTRAR</b> <u>FEB 16 1966</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>						



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>																	
<b>1. PLACE OF DEATH</b> a. COUNTY <u>BALTIMORE</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GARRISON</u> c. LENGTH OF STAY IN 1b <u>8 DAYS</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>FOXLEIGH NURSING HOME</u>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>V</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> d. STREET ADDRESS <u>3348 DOLFIELD AVE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) <u>JACOB DICKLER</u>			<b>4. DATE OF DEATH</b> Month <u>2</u> Day <u>1</u> Year <u>1966</u>			<b>5. SEX</b> <u>Male</u>			<b>6. COLOR OR RACE</b> <u>White</u>			<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			<b>8. DATE OF BIRTH</b> 9. AGE (in years last birthday) <u>72</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>STORE KEEPER (MERCHANDISE)</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>RETAIL GROCERIES</u>						<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>RUSSIA</u>			<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>								
<b>13. FATHER'S NAME</b> <u>ABRAHAM DICKLER</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>LIEBERMAN, JENNIE</u>											
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)			<b>16. SOCIAL SECURITY NO.</b> <u>312-40-5926</u>			<b>17. INFORMANT</b> <u>MRS. ROSE DICKLER</u>			<b>Address</b> <u>3348 DOLFIELD AVE</u>								
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>4-201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerosis</u> DUE TO (c)												<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>Hours</u> <u>unknown</u>					
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b> <u>Malnutrition</u>												<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>						<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)											
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)									
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>1-24</u> , 19 <u>66</u> , <b>to</b> <u>Feb 1</u> , 19 <u>66</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>1-29</u> , 19 <u>66</u> , <b>and that death occurred at</b> <u>11:57 PM</u> , <b>from the causes and on the date stated above.</b>																	
<b>22a. SIGNATURE</b> <u>David J. Miller</u> M.D.						<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/>		<b>MED. DIRECTOR</b> <input type="checkbox"/>		<b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>Feb. 1 - 1966</u>					
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>David J. Miller</u>						<b>22d. ADDRESS</b> <u>Foxleigh Nursing Home</u>											
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>			<b>23b. DATE THEREOF</b> <u>2/3/66</u>			<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>SHAAREI TFILOH</u>			<b>23d. LOCATION (City, town, or county)</b> (State) <u>BALTIMORE, MARYLAND</u>								
<b>24. FUNERAL DIRECTOR</b> <u>SOL LEVINSON &amp; BROS. INC. 6010 REISTERSTOWN RD</u>						<b>25a. REC'D BY REGISTRAR</b> <u>DATE FEB 7 1966</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01866 CERTIFICATE OF DEATH 01815											
1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTIMORE</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>118 PATAPSCO AVE.</u>						d. STREET ADDRESS <u>118 PATAPSCO AVE</u>				e. IS RES. DENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>GEORGE A. DIMLER (AKA MICHAEL G.)</u>						4. DATE OF DEATH <u>FEBRUARY 2 1966</u>					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>17 FEB. 1909</u>		9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WHEEL OPERATOR</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>STEEL</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ANDREW DIMLER</u>						14. MOTHER'S MAIDEN NAME <u>MARGARET SCHETTL</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>213-09-3670</u>		17. INFORMANT Address <u>BARBARA DIMLER, 21222 118 PATAPSCO AVE.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Sigmoid Colon</u> <u>1533</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <u>15 hrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <u>1-31 1966</u> to <u>Feb 2 1966</u> that (I) (we) last saw the deceased alive on <u>1-31 1966</u> and that death occurred at <u>11:31</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>W. K. Wong</u>						22b. DATE SIGNED <u>2-4-66</u>		22c. PHYSICIAN'S NAME (Type) <u>W. K. Wong</u>			
22d. ADDRESS <u>6901 Gunmanway 12</u>						22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2-7-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>HOLY REDDEMER</u>				23d. LOCATION (City, town or county) (State) <u>BALTIMORE, MD.</u>			
24. FUNERAL DIRECTOR ADDRESS <u>WILLIAM FUNERAL HOME, DUNDALK, MD.</u>						25a. REC'D BY REGISTRAR <u>FEB 10 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

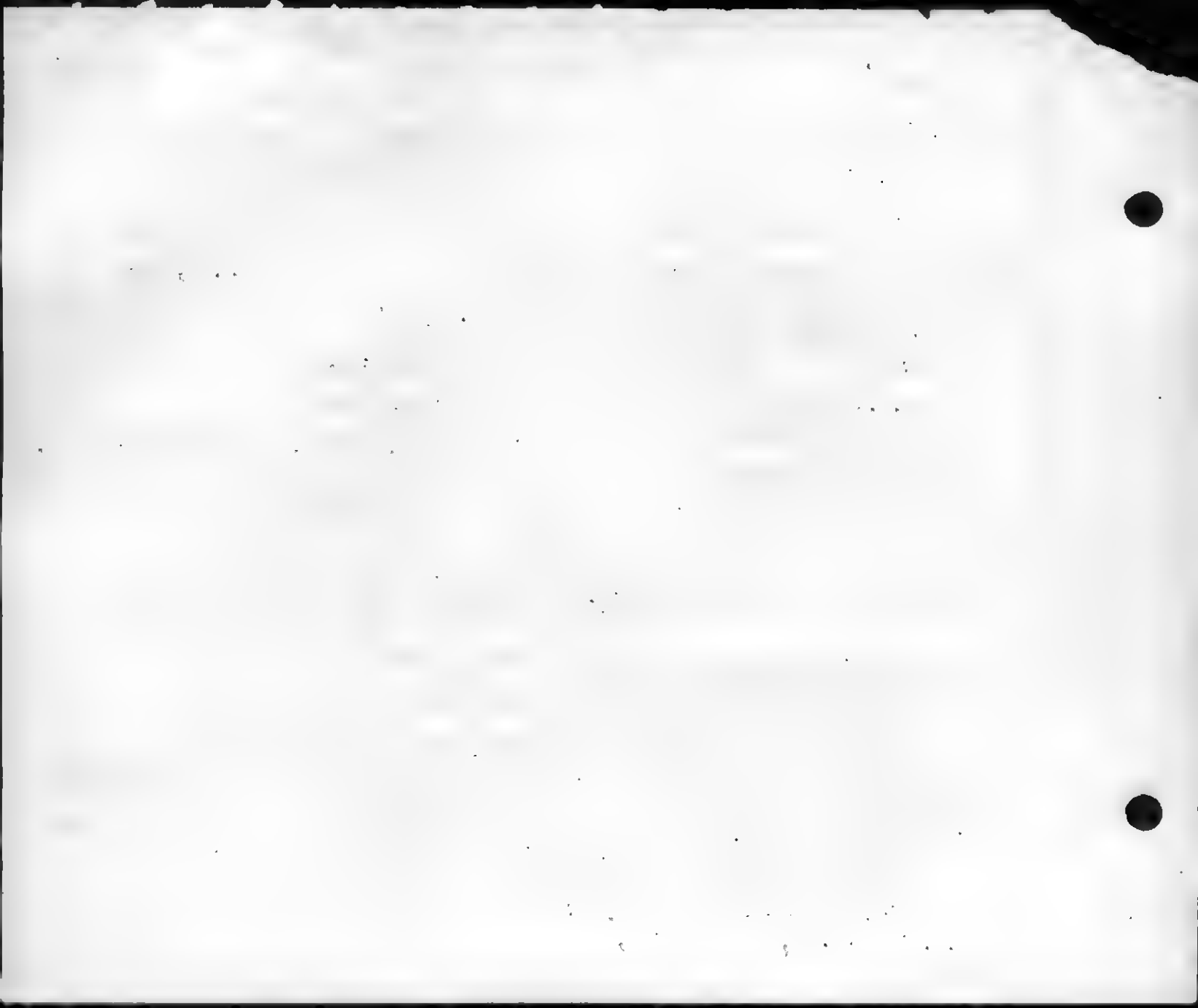
B.P.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

01867

01816

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Howard</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Marriottsville</b>		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>WILLIAM DOMINIC DONOVAN</b>		4. DATE OF DEATH <b>Feb. 23, 1966</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Mar. 21, 1900</b>		9. AGE (In years last birthday) <b>65 yrs.</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Woodstock, Md</b>		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>Wm. D. Donovan</b>		14. MOTHER'S MAIDEN NAME <b>M. Grace Brown</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFIRMANT <b>Miss Mary G. Donovan, 4423 Alan Drive, Balto.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cardiac Arrhythmia</b> <b>4331</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Myocardial Degeneration</b> DUE TO (c) <b>Generalized Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>June</b> , 1960, to <b>23 Feb</b> , 1966, that (I) (we) last saw the deceased alive on <b>23 Feb</b> , 1966, and that death occurred at <b>23 Feb</b> , 1966, from the causes and on the date stated above.		22a. SIGNATURE <b>William J. Bryson</b>		22b. DATE SIGNED <b>25 Feb 66</b>		22c. PHYSICIAN'S NAME (Type) <b>William J. Bryson</b>		22d. ADDRESS <b>4606 Edmondson Ave</b>		22e. M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-26-1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Alphonsus</b>		23d. LOCATION (City, town or county) (State) <b>Woodstock, Md</b>		24. FUNERAL DIRECTOR <b>F.C. Higinbotham, Ellicott City, Md</b>		25a. REC'D BY REGISTRAR <b>FEB 28 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 4 may be retained by the hospital or attending physician.

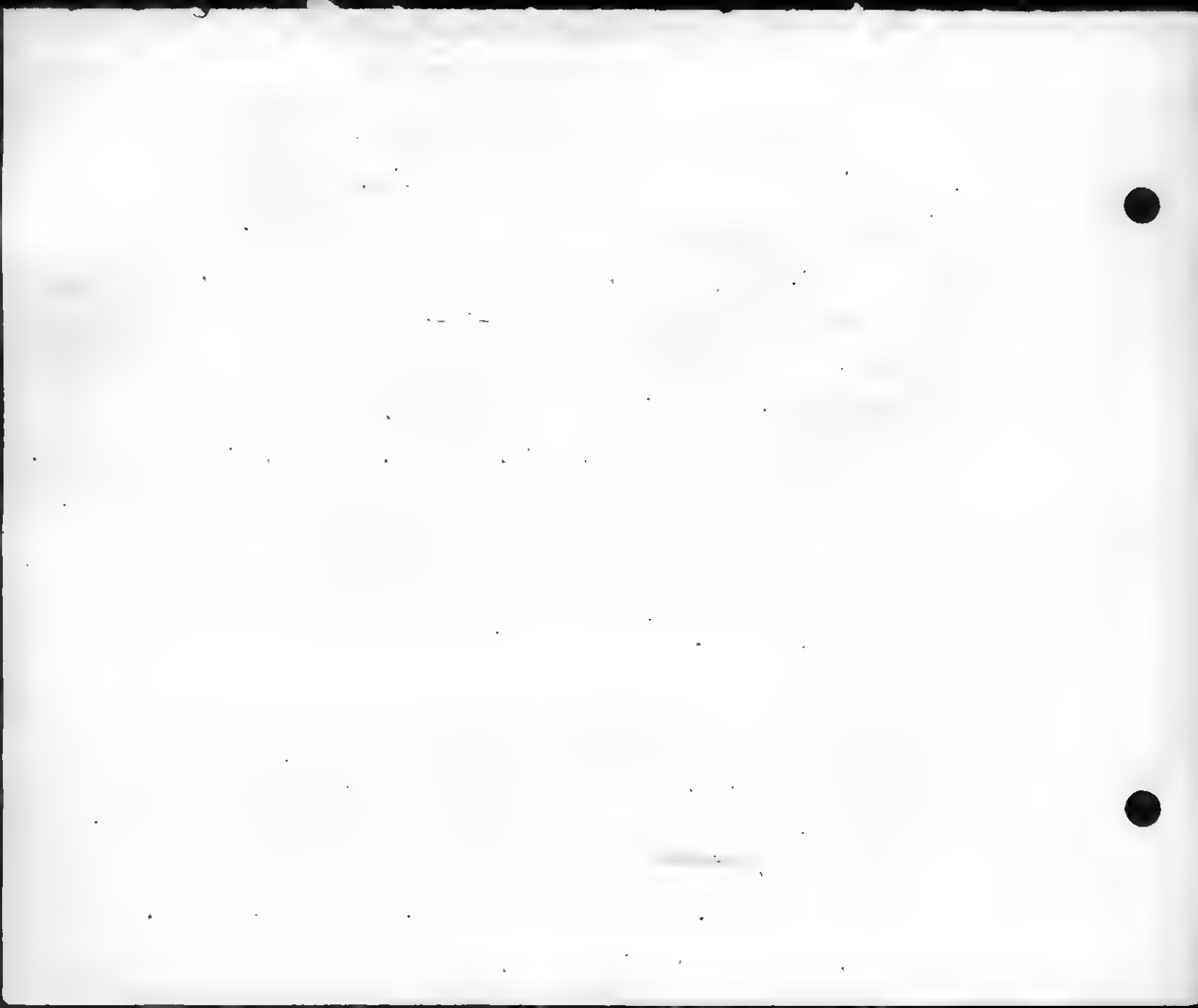
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

01868

01817

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore #18</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Ridgeway Manor Nursing Home</u>		d. STREET ADDRESS <u>753 Melville Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Loyola</u> Middle <u>C.</u> Last <u>Doughney</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>16</u> Year <u>1966</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-12-1899</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Clocker</u>		14. MOTHER'S MAIDEN NAME <u>Ida E. Edwards</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-34-4110 A</u>	
17. INFORMANT <u>Mr. Joseph W. Doughney, 3206 Willoughby Rd.</u>		Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>173X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Carcinoma of breast</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>10 Feb</u> , 19 <u>66</u> , to <u>16 Feb</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>16 Feb</u> 19 <u>66</u> , and that death occurred at <u>10:12</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>William Goodman</u>		22b. DATE SIGNED <u>17 Feb 66</u>	
22c. PHYSICIAN'S NAME (Type) <u>WILLIAM GOODMAN, MD</u>		22d. ADDRESS <u>1334 SOLDNER SPRING RD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2/19/66.</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Baltimore Md.</u>
24. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc Baltimore, Md.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>FEB 18 1966</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 2 and 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove page 3 from this certificate and file it with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

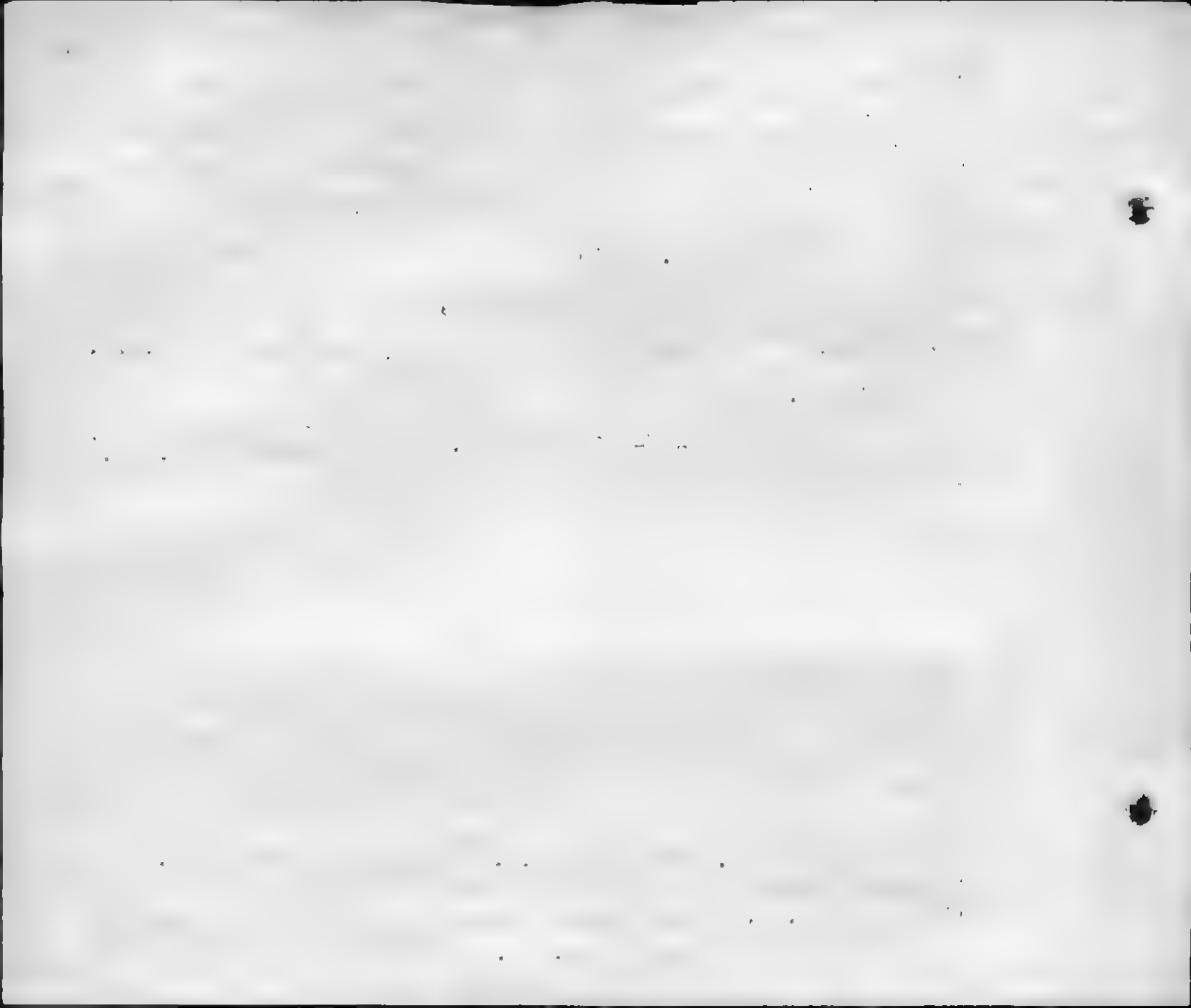
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

01869

01818

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b> c. LENGTH OF STAY IN 1b <b>3 years</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>137 Tollgate Road</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b> d. STREET ADDRESS <b>137 Tollgate Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Mac Lee O. Dulin</b> First Middle Last		4. DATE OF DEATH <b>February 16 1966</b> Month Day Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 29, 1886</b> Year
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cabinet Maker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Household goods</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Easton, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William H. Dulin</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Dulin</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-05-3439</b>	
17. INFORMANT <b>Ralph E. Dulin</b>		Address <b>137 Tollgate Road, Owings Mills, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer - stomach</b> <b>151X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>1 year</b> (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Interval between onset and death</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>January 15, 1966</b> to <b>February 16, 1966</b> that (I) (we) last saw the deceased alive on <b>February 13, 1966</b> and that death occurred <b>8:15 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Clarence E. McWilliams</b> M.D.		22b. DATE SIGNED <b>February 18, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Clarence E. McWilliams M.D. Reisterstown, Maryland.</b>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Feb. 19, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cemetery Woodlawn, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>H J Eckhardt</b>		25a. REC'D BY REGISTRAR <b>FEB 21 1966</b>	
ADDRESS <b>Owings Mills, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a COUNTY <b>Baltimore</b>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Timonium</b>		c. LENGTH OF STAY IN 1b <b>1 Hr.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>York Road Medicial Center</b>		e. STREET ADDRESS <b>104 Aylesburg Road</b>	
3 NAME OF DECEASED (Type or print) <b>CARLYLE THOMAS DUNNOCK</b>		4 DATE OF DEATH Month <b>February</b> , Day <b>9</b> , Year <b>19 66</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>May 27, 1919</b>
9 AGE (in years last birthday) yrs <b>46</b>		10 IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	
11 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Asst. Transportation</b>		12 C. KIND OF BUSINESS OR INDUSTRY <b>Board of Ed.</b>	
13. FATHER'S NAME <b>Thomas Morris Dunnock</b>		14. MOTHER'S MAIDEN NAME <b>Ellis Montgomery</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16 SOC. A. SECURITY NO <b>215-16-2004</b>	
17 INFORMANT <b>Mrs. Hilda Lee Dunnock, Same as #2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) (c) PART I OTHER SIGNIF. COND. CONTR. BUT NOT RELATED TO THE TERMINAL DISEASE COND. T. ON GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>3 hours</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item B)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles O. Towson</b> M.D. EXAMINER'S NAME (Type)		22. DATE SIGNED <b>2/9/66</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, or REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Feb. 12, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore Maryland</b>
24. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Towson, Towson 4, Maryland</b>		25a. REC'D BY REGISTRAR <b>FEB 14 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

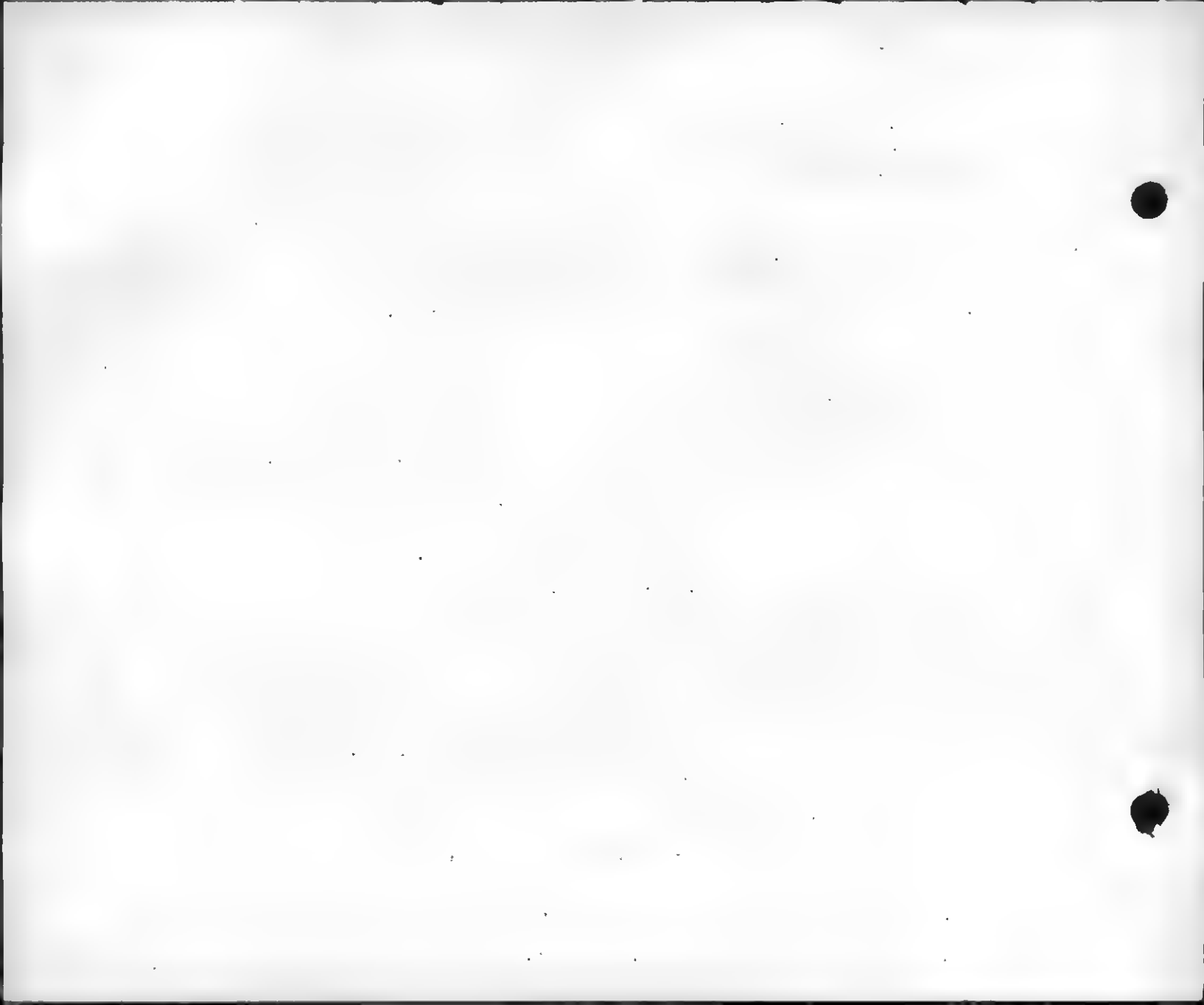
1 PLACE OF DEATH a. COUNTY <u>Baltimore County</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 21204</u>		c. LENGTH OF STAY IN 1b <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Saint Joseph's</u>		d. STREET ADDRESS <u>1634 Loch Ness Road #4</u>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Anthony</u> Last <u>Durm</u>		4. DATE OF DEATH Month <u>February</u> Day <u>3</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-17-1916</u>
9. AGE (In years last birthday) <u>49</u> yrs		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Acme Fast Freight</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John L. Durm</u>		14. MOTHER'S MAIDEN NAME <u>Alice Ryer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes</u> <u>2-8-45-10-23-46</u>		16. SOCIAL SECURITY NO. <u>212-03-8934</u>	
17. INFORMANT <u>Mrs. Leo DeLuca</u>		Address <u>8303 Pleasant Plains Rd., #4</u>	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <u>4201</u> IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Charles T. Donnell</u> M.D. EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>2136 E. 3rd St. Judge</u>	
22. DATE SIGNED <u>2/3/66</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/5/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Clement</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore</u>	
24. FUNERAL DIRECTOR <u>W. Beermann 6067 Hamp. Rd.</u>		25a. REC'D BY REGISTRAR <u>8 10 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>W. Beermann</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				
c. LENGTH OF STAY IN 1b <u>28</u>					d. STREET ADDRESS <u>311 Cathedral St.</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>CATON RIDGE NURSING HOME</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last <u>DUZOR, ANNE (ANNA)</u>					4. DATE OF DEATH Month Day Year <u>2 - 20 - 19 66</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 25, 1894</u>		9. AGE (In years last birthday) <u>71</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Duzor</u>					14. MOTHER'S MAIDEN NAME <u>Eva Franko</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>214-03-2607</u>		17. INFORMANT Address <u>Joseph G. Duzor 311 Cathedral St.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary Emphysema</u> DUE TO (c) <u>Kyphoscoliosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Generalized Arteriosclerosis</u>									INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>4 - 20 - 1966</u> , to <u>2 - 20 - 1966</u> , that (I) (we) last saw the deceased alive on <u>2 - 20 - 1966</u> , and that death occurred at <u>      </u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>Cesar Valle Caverio</u>								22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>CESAR VALLE CAVERIO</u>					22d. ADDRESS <u>8624 Liberty Road</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>2/24/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>		
24. FUNERAL DIRECTOR <u>Wm. Cook-Brooks Inc. 1217 St. Paul St. 21202</u>					25a. REC'D BY REGISTRAR <u>FEB 23 1966</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		



1  
FOR STATE  
HEALTH DEPT.

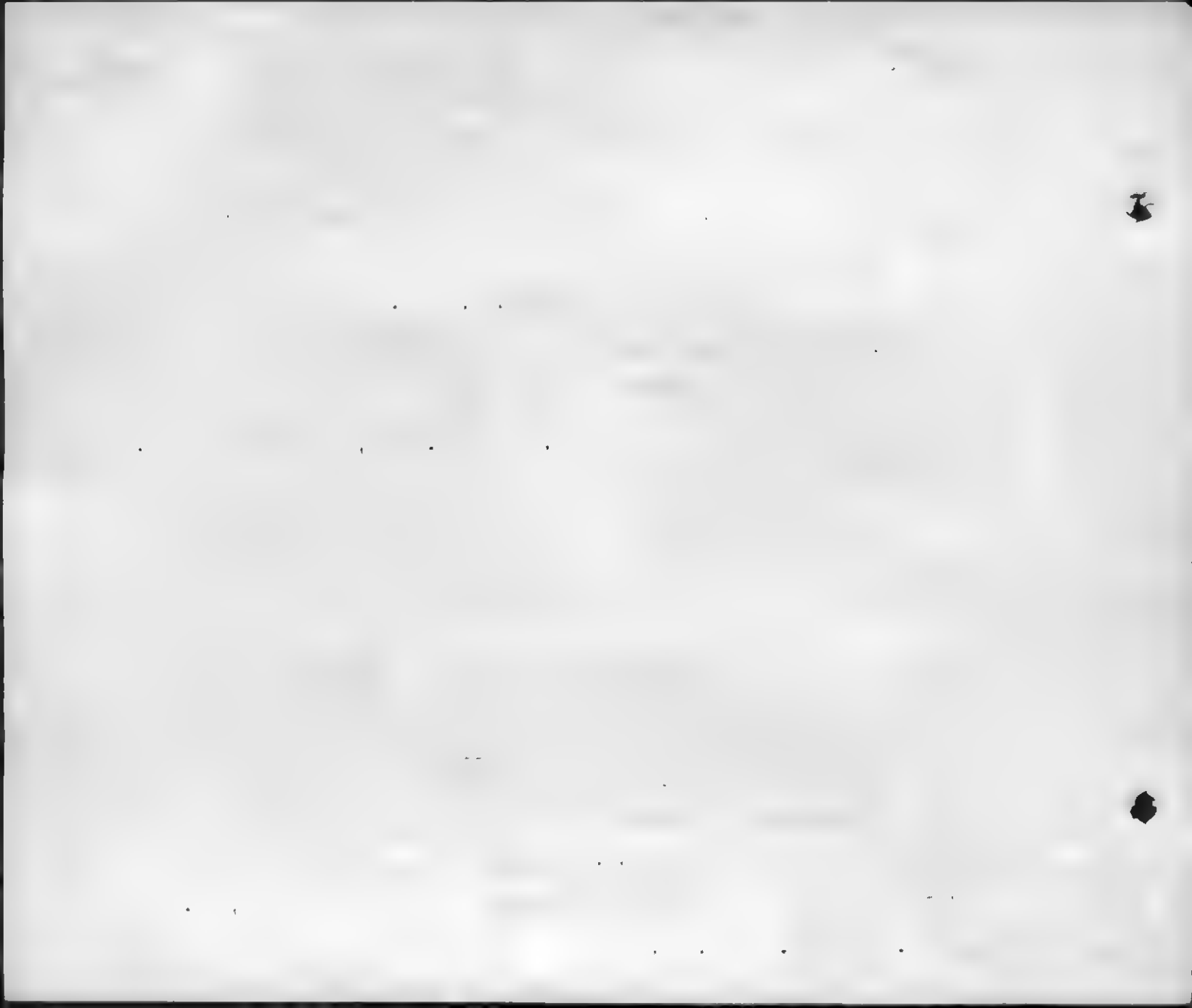
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

Item 206 Film G-73 MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
01873 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01822

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore-rural</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>1301 Heatherhill Rd.</b>		2. USUAL RESIDENCE (Where deceased lived, if institutional on Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore-rural</b> d. STREET ADDRESS <b>1301 Heatherhill Rd.</b>	
3. NAME OF DECEASED (Type or print) <b>HELEN BERTHA ECK</b>		4. DATE OF DEATH Month <b>2</b> Day <b>1</b> Year <b>19 66</b>	
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <b>Sept. 3, 1905.</b>		9. AGE (In years last birthday) <b>60</b> IF UNDER 1 YEAR Months Days Hours M.in.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Liersemann</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Mr. Robert B. Kelm, 1105 Longbrook Rd. 21093</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia</b> DUE TO <b>carbon monoxide poisoning</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. 19. WAS AUTOPSY PERFORMED? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY, or CONTRIBUTING CAUSE OF DEATH <b>The fumes were from the house furnace apparently overcome by carbon monoxide</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>?</b> p.m. <b>?</b> 19 <b>66</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>home</b>		20f. (City or town) <b>Baltimore</b> (County) <b>Balto.</b> (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Rudiger Breitenecker</b>		M.D.	
EXAMINER'S NAME (Type) <b>Rudiger Breitenecker, M.D.</b>		DATE SIGNED <b>2-2-66</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/7/66</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc. Balto. Md. 21214</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>FEB 4 1966</b>		24b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

MEDICAL CERTIFICATION



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

Item 206 Film G373 MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

**01874** **01823**

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

1. PLACE OF DEATH  
a. COUNTY **Baltimore** **MARYLAND**  
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **Baltimore-rural**  
c. LENGTH OF STAY IN lb  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) **1301 Heatherhill Rd.**

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)  
a. STATE **Maryland** b. COUNTY **Baltimore**  
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **Baltimore-rural**  
d. STREET ADDRESS **1301 Heatherhill Rd.**

3. NAME OF DECEASED (Type or print) **MELVIN WASHINGTON ECK, Sr.**  
4. DATE OF DEATH **2-1-66**

5. SEX **male** 6. COLOR OR RACE **white** 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH **July 11, 1897.**  
9. AGE (In years last birthday) **68** 10. IF UNDER 1 YEAR: Months **68** Days **68** Hours **68** Min. **68**

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Sales** 10b. KIND OF BUSINESS OR INDUSTRY **Morris Eckles Co.** 11. BIRTHPLACE (State or foreign country) **Maryland** 12. CITIZEN OF WHAT COUNTRY? **USA**

13. FATHER'S NAME **Oscar Eck** 14. MOTHER'S MAIDEN NAME **Unknown Mammie Belt**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **No** 16. SOCIAL SECURITY NO **212-03-0887** 17. INFORMANT **Mr. Robert B. Kelm, 1105 Longbrook Rd. 21093**

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) **Asphyxia**  
**7900** DUE TO **Carbon monoxide poisoning**  
Conditions, if any, which gave rise to immediate cause (b) }  
(a), stating the underlying cause last. (c) }  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c).  
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING CAUSE OF DEATH. **The fumes were from the house furnace**  
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or of item 18.) **Apparently overcome by carbon monoxide**

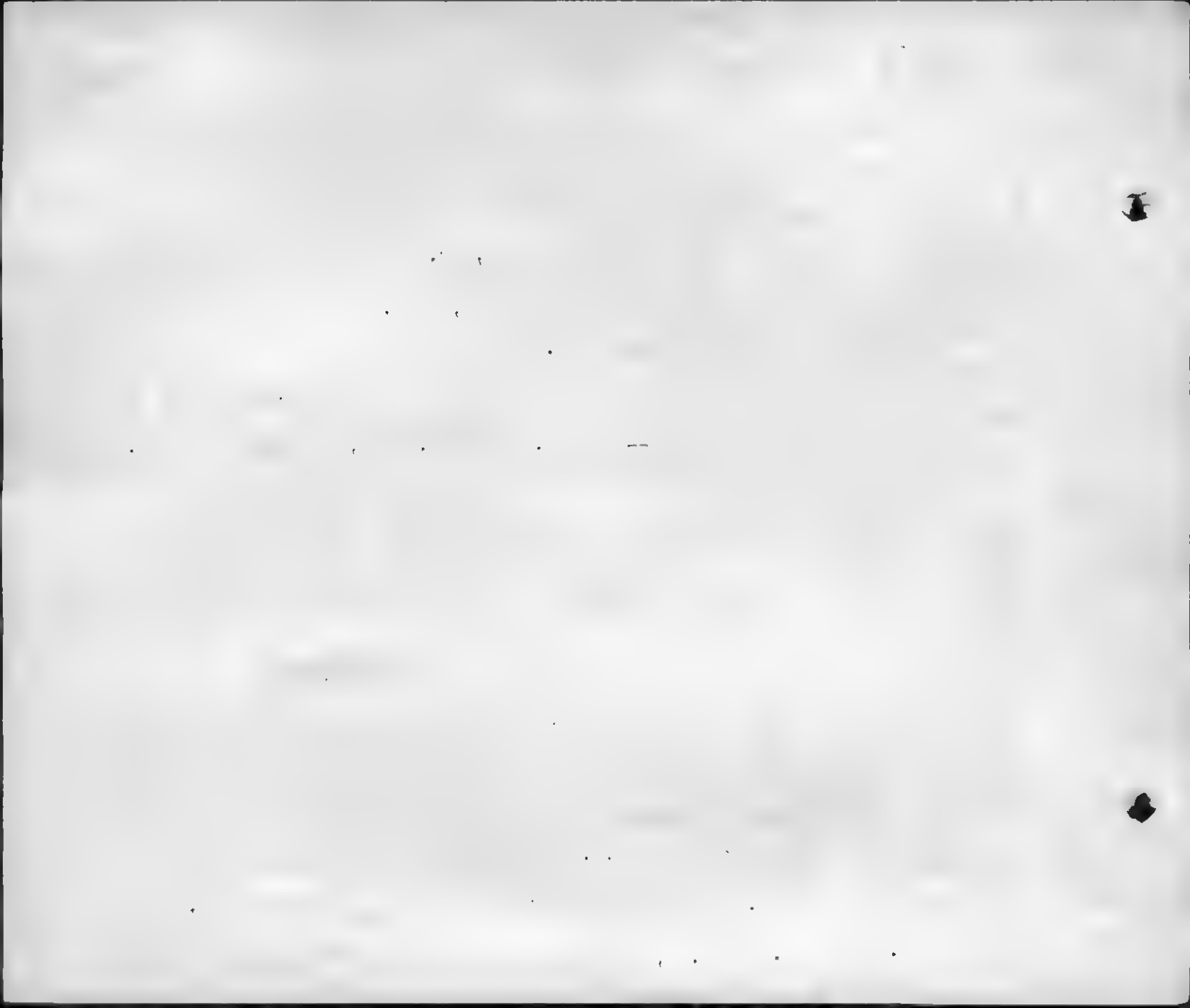
20c. TIME OF INJURY Month, Day, Year **? 1966** 20d. INJURY OCCURRED While ☐ at work ☒ at work ☒ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) **home** 20f. (City or town) **Baltimore** (County) **Balto.** (State) **Md.**

21 I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE **R. Breiteneker** CHIEF MEDICAL EXAMINER ☐  
EXAMINER'S NAME (Type) **Rudiger Breiteneker, M.D.** ASSISTANT MEDICAL EXAMINER ☒ DATE SIGNED **2-2-66**  
DEPUTY MEDICAL EXAMINER ☐ Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 22b. DATE THEREOF **2/7/66.** 22c. NAME OF CEMETERY OR CREMATORY **Parkwood Cemetery** 22d. LOCATION (City, town, or county) **Baltimore Md.** (State)

23. FUNERAL DIRECTOR **Leonard J. Ruck Inc. Balto. Md. 21214** ADDRESS  
24a. REC'D BY REGISTRAR **FEB 4 1966** 24b. REGISTRAR'S SIGNATURE **J. J. Jones**



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

01875

01824

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore 34</b> c. LENGTH OF STAY IN <b>lb</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>1815 Deveron Road</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore 34</b> d. STREET ADDRESS <b>1815 Deveron Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>FANNIE AGNES EDWARDS</b> First Middle Last				<b>4. DATE OF DEATH</b> <b>February 15, 19 66</b> Month Day Year			
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>December 6, 1888</b> <b>77</b> yrs.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Sales</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Dept. Stores</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Virginia</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>Thomas Javin Rock</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Arinthia Webb</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b>				<b>16. SOCIAL SECURITY NO.</b> <b>218-05-9340A</b> <b>Mr. Leslie M. Edwards, 1201 McGurley, Balto. 28.</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> DUE TO (b) <b>Plumery</b> (c) <b>Heart</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, notify medical examiner)							
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from Jan. 27, 1966, to Feb. 15, 1966, that (I) (we) last saw the deceased alive on Feb. 14, 1966, and that death occurred at 2:30 P.M. from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <b>G.M. Nasim</b>				<b>22b. DATE SIGNED</b> <b>21204</b>			
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>G.M. Nasim, M.D.</b>				<b>22d. ADDRESS</b> <b>246 Burke W nue Towson, Md.</b>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>Feb. 18, 1966</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Loudon Park Cemetery</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>Baltimore, Maryland</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Wm. Cook-Brooks Towson, 1050 York Road Towson 4, Maryland</b>							

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

01876

01825

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u> c. LENGTH OF STAY IN 1b <u>18 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>705 MILFORD MILL ROAD</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u> d. STREET ADDRESS <u>705 Milford Mill Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>FREDERICK H. EINWAECHTER, SR.</u> <u>Frederick Henry Einwaechter, Sr.</u>		<b>4. DATE OF DEATH</b> Month <u>Feb</u> Day <u>19</u> Year <u>1966</u>	
<b>5. SEX</b> <u>M</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>Sept 25, 1869</u> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>9. AGE (In years last birthday)</b> <u>96</u> yrs. <b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u> <b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Court Clerk</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Baltimore City Court</u> <b>11. BIRTHPLACE (County &amp; State, or foreign country)</b> <u>Baltimore City Md.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>GEORGE ALEXANDER</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Mrs ELIZABETH WEYRICH</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> <b>16. SOCIAL SECURITY NO.</b> <u>[REDACTED]</u> <b>17. INFORMANT</b> <u>Mrs Glendora Hinrichs</u> Address <u>705 Milford Mill Rd. Pikesville 8, Md.</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease</u> DUE TO (b) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: <u>  </u>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>  </u> 19 <u>  </u> Hour a.m. <u>  </u> p.m. <u>  </u>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office b.d.g., etc.) <u>  </u>	<b>20f. (City or town)</b> <u>  </u> (County) <u>  </u> (State) <u>  </u>
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>1950</u> 19 <u>  </u> , to <u>Feb 19</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Feb 19</u> 19 <u>66</u> , and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <u>Paul H Royse</u>		<b>22b. DATE SIGNED</b> <u>Feb 19 1966</u>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>PAUL H ROYSE</u>		<b>22d. ADDRESS</b> <u>1403 Foley Lane Pikesville Md.</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>	<b>23b. DATE THEREOF</b> <u>2/24/66</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>LOUDON PARK CEMETERY</u>	<b>23d. LOCATION (City, town or county)</b> <u>BALTIMORE, MARYLAND</u>
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>HUBBARD FUNERAL HOME, 4107 WILKENS AVENUE 21229</u>		<b>25a. REC'D BY REGISTRAR</b> <u>FEB 23 1966</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>[Signature]</u>	



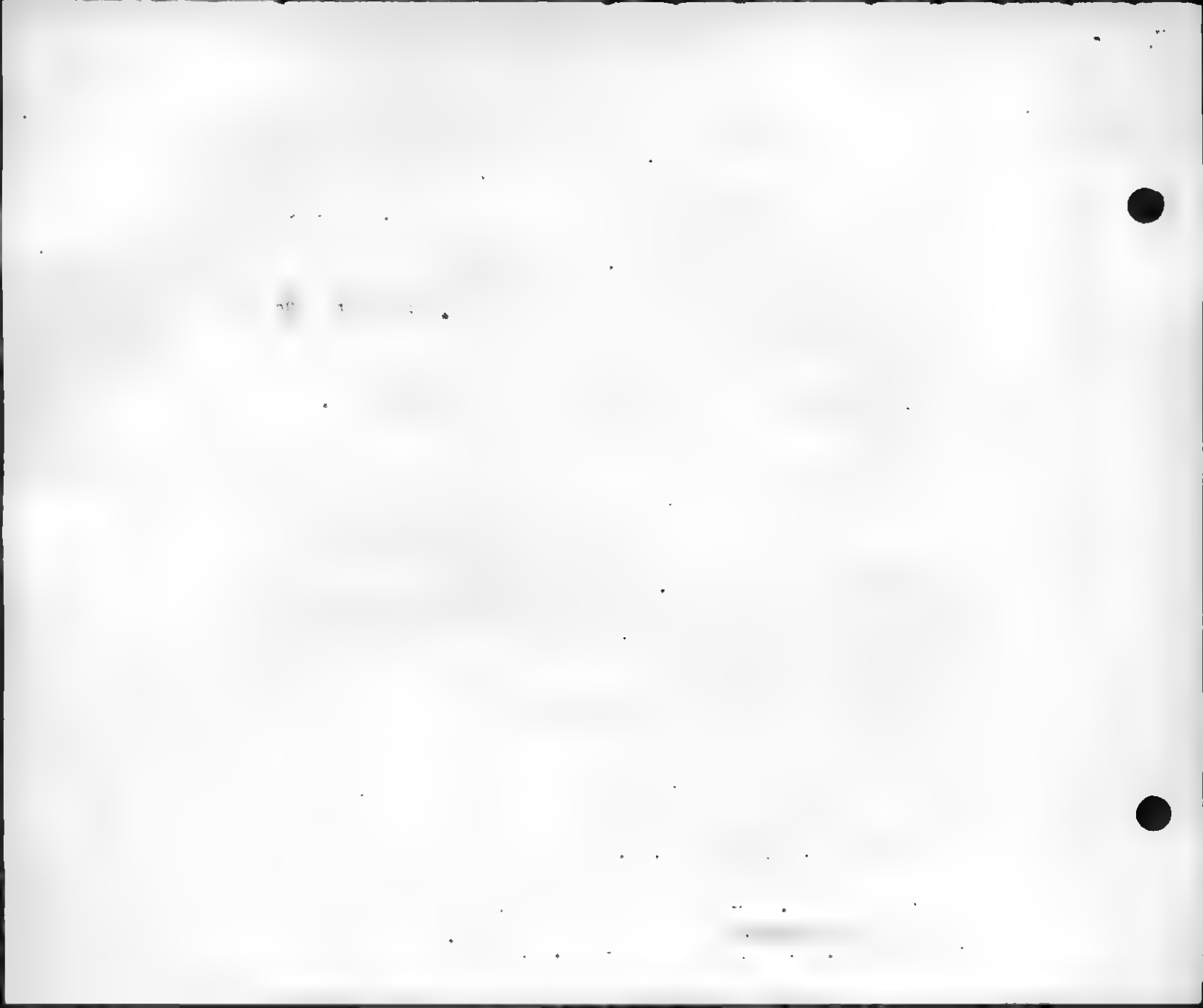
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it is completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
01877 CERTIFICATE OF DEATH 01826

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN 1b <b>2mth 4dys</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Silver Hill, Maryland</b> d. STREET ADDRESS <b>3613 St. Barnabas Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Rose K. Eldeen</b>			4. DATE OF DEATH Month <b>February</b> Day <b>10</b> Year <b>1966</b>				
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 25, 1885</b>	9. (In years birthday) <b>80</b> yrs.	IF UNDER 1 YEAR Months <b>1</b> Days <b>10</b> Hours <b>19</b> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTH PLACE (County & State, or foreign country) <b>Hungary</b>			
13. FATHER'S NAME <b>Joseph Kalmar</b>			14. MOTHER'S MAIDEN NAME <b>Mary Unk.</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>Generalized arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cancer of right breast</b>					INTERVAL BETWEEN ONSET AND DEATH		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that <del>the</del> (this hospital) attended the deceased from <b>Dec. 6, 1965</b> to <b>Feb. 10, 1966</b> , that <del>the</del> (we) last saw the deceased alive on <b>Feb. 10, 1966</b> , and that death occurred at <b>4:15</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <i>Imre Kopits</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2-10-66</b>			
22c. PHYSICIAN'S NAME (Type) <b>Imre Kopits, M. D.</b>		22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Feb. 14-1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Suitland, Maryland</b>			
24. FUNERAL DIRECTOR <b>Simmons Bros.</b>		ADDRESS <b>SE Wash. D.C. Hope RD</b>		25a. REC'D BY REGISTRAR <b>FEB 15 1966</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

732



FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in the blank space. Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

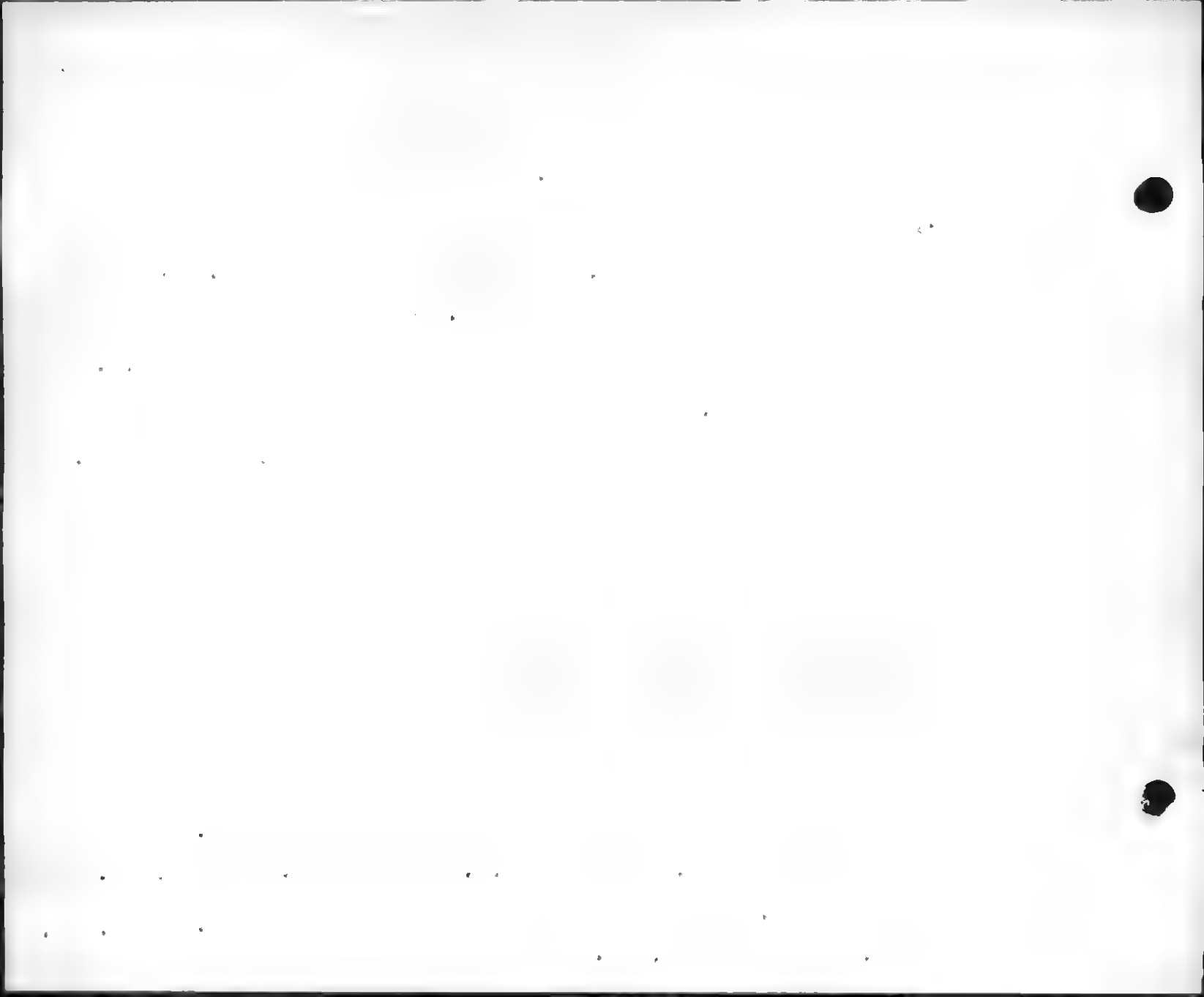
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01878

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01827

1 PLACE OF DEATH a COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, first location Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Baltimore</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>		c LENGTH OF STAY IN 1b <b>28 yrs.</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Res., 2901 Gray Manor Terrace</b>		e STREET ADDRESS <b>2901 Gray Manor Terrace</b>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>MYRTLE M. Entwistle</b>		4 DATE OF DEATH Month Day Year <b>Feb. 7- 1966</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Sept. 2-1905</b>
9 AGE (In years last birthday) <b>60</b>		F UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>Andrew P. Herget</b>		14 MOTHER'S MAIDEN NAME <b>Mary Schmeiser</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>None</b>	
17 INFORMANT <b>Son, John Entwistle, Dundalk, Md. 21222</b>		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Primary Edema</b> <b>4200</b> DUE TO (b) <b>Heart Failure</b> Condit ions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <b>Arteriosclerotic Heart Disease</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day Year Hour a.m. p.m. <b>19</b>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Theodore C. Patterson</b> EXAMINER'S NAME (Type) <b>Theodore C. Patterson M.D.</b>		22 DATE SIGNED <b>Feb. 7-1966</b>	
23a BURIAL CREMATION, REMOVAL <b>Burial</b>		23b DATE THEREOF <b>Feb. 9-1966</b>	
23c NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>		23d LOCATION (City or town) (County) (State) <b>Taylor Ave. Balto. Md.</b>	
24 FUNERAL DIRECTOR <b>JOHN J. DUDA, Dundalk, Md. 21222</b>		25a REC'D BY REGISTRAR DATE <b>9 9 1966</b>	
25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

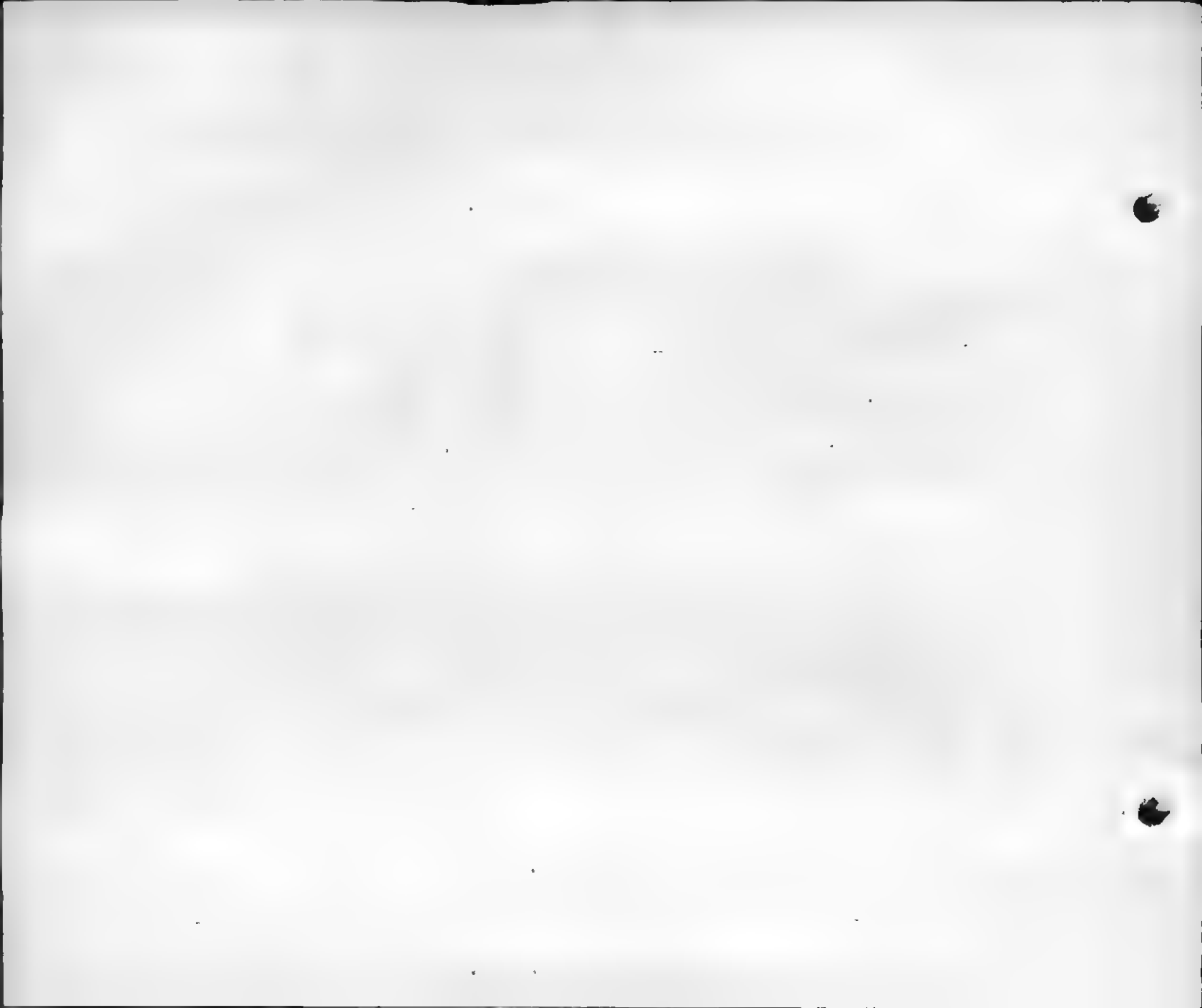
## CERTIFICATE OF DEATH

Reg. Dist. No. **01828**

**01879**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>BALTIMORE</b> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution. Residence before admission) a. STATE <b>MARYLAND</b> <span style="float: right;">b. COUNTY <b>BALTIMORE</b></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <b>CATONSVILLE</b>			c. LENGTH OF STAY IN 1b 				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SHADY NOOK NURSING HOME 21228</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
<b>3. NAME OF DECEASED</b> (Type or print) First <b>CARRIE</b> Middle <b>HARGIS</b> Last <b>EVANS</b>			<b>4. DATE OF DEATH</b> Month <b>X 2</b> Day <b>2</b> Year <b>19 66</b>				
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <b>March 13, 1872</b>		9. AGE (In years last birthday) <b>93</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>		11. BIRTHPLACE (State or foreign country) <b>Somerset County, Maryland</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>William T. Hargis</b>					
14. MOTHER'S MAIDEN NAME <b>Sarah Elizabeth Coston</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No --</b>					
16. SOCIAL SECURITY NO <b>None</b>		17. INFORMANT Address <b>William H. Evans, Hyattsville, Maryland</b>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Arteriosclerosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis - generalized</b> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <b>4 hrs</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <b>April 29, 1962</b> to <b>Feb 2, 1966</b> , that I last saw the deceased alive on <b>2-2-66</b> , 19 <b>66</b> , and that death occurred at <b>1:15</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED					
ACTUAL SIGNATURE <b>A. Bradley Daugharthy</b> M.D. <b>1264 Francis Ave Baltimore 27 Md 2-266</b>		PHYSICIAN'S NAME (Type) <b>A. Bradley Daugharthy, M.D.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-5-1966</b>		22c. NAME OF CEMETERY <b>Pocomoke</b>			
22d. LOCATION (City, town, or county) (State) <b>Pocomoke City, Maryland</b>		24a. REC'D BY REGISTRAR <b>FEB 7 1966</b>					
24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		24c. REGISTRAR'S ADDRESS <b>Watson Funeral Home Pocomoke City, Md.</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>B</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baltimore City General</u>		d. STREET ADDRESS <u>2414 20th St. Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Lillian LaVern Felton</u>		4. DATE OF DEATH <u>Feb 1 1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/26/24</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harry Lancaster</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Hoffman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Mrs. Lola Kemp</u>		Address <u>1234 Brewster</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> 592X DUE TO (b) <u>Anemia</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) <u>Chronic Nephritis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Blond M.D.</u>		22b. DATE SIGNED <u>2-1-66</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <u>BALTIMORE COUNTY GENERAL HOSP.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>2/5/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MEADOWRIDGE MEMORIAL PARK</u>	23d. LOCATION (City, town or county) (State) <u>BALTIMORE, MARYLAND</u>
24. FUNERAL DIRECTOR <u>HUBBARD FUNERAL HOME, 4107 WILKENS AVE. 21229</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE	

السلامة العامة  
والصحة العامة  
والبيئة العامة  
والثقافة العامة  
والرياضة العامة  
والفنون العامة  
والعلوم العامة  
والصناعة العامة  
والخدمات العامة  
والسياحة العامة  
والترفيه العامة  
والرياضة العامة  
والفنون العامة  
والعلوم العامة  
والصناعة العامة  
والخدمات العامة  
والسياحة العامة  
والترفيه العامة

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

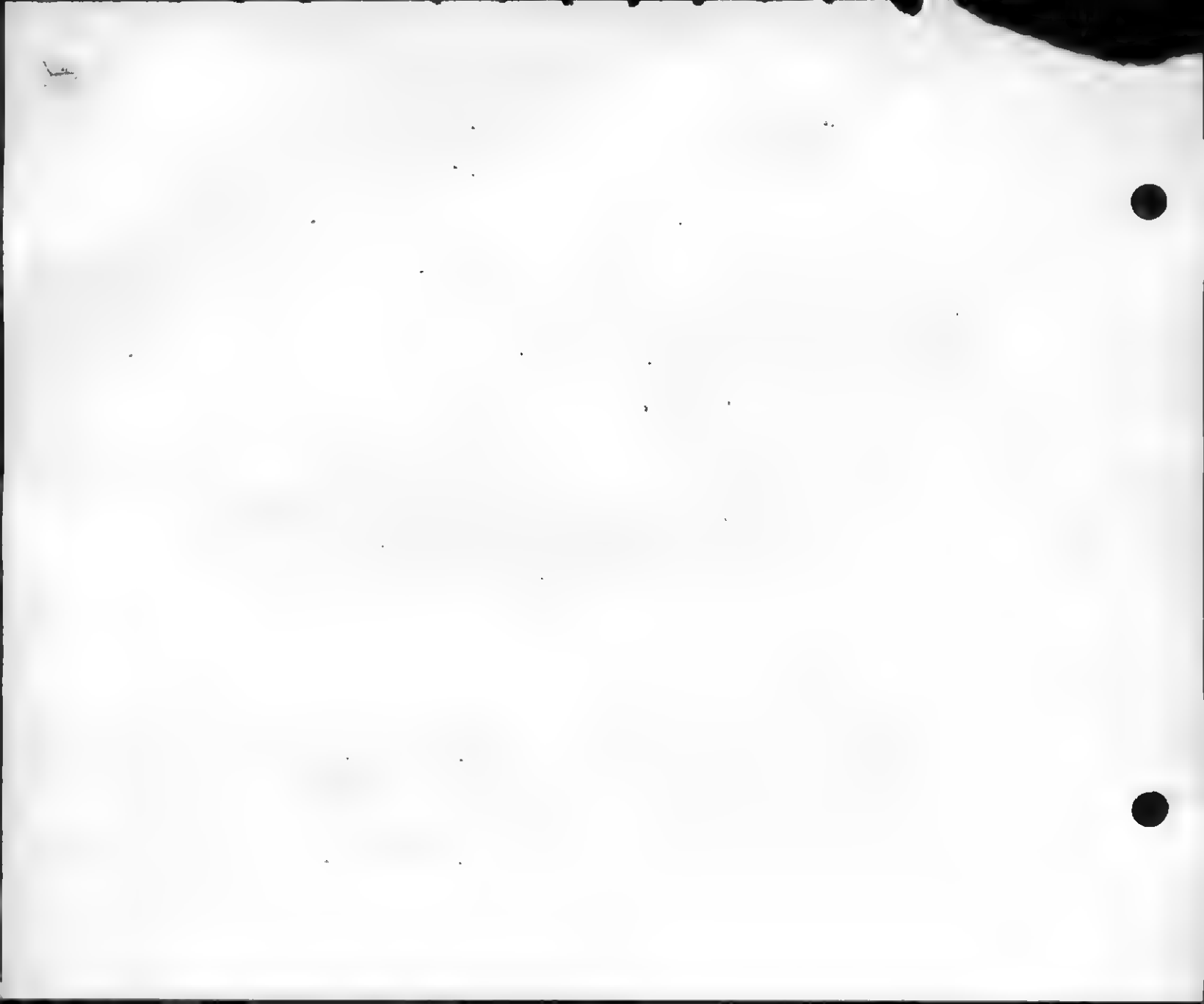
01881

Item #3 File #33132/15/66

CERTIFICATE OF DEATH

01830

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore 21206</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>St. Joseph Hospital</b>		d. STREET ADDRESS <b>5835 Belair Rd.</b>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Henry</b> Last <b>Fenner</b>		4. DATE OF DEATH Month <b>2</b> Day <b>10</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 12, 1905</b>
9. AGE (In years last birthday) <b>60 yrs.</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Commercial Serviceman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Balto. Gas &amp; Electric Maryland</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Henry Fenner</b>		14. MOTHER'S MAIDEN NAME <b>Lydia Pearce</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-05-2719</b>	
17. INFORMANT <b>Mrs Estelle Fenner</b>		Address <b>5835 Belair Road #6</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Status post partial resection of abdominal aneurysm with teflon bypass and splenectomy</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hemoperitoneum and Hemothorax, left</b> DUE TO (c) <b>Hypostatic congestion, severe</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1/20/</b> , 1966, to <b>2/10/</b> , 1966, that (I) (we) last saw the deceased alive on <b>2/10/</b> , 1966, and that death occurred at <b>2:25 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>D.R. Govinda Rao</b>		22b. DATE SIGNED <b>2/10/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>D.R. Govinda Rao</b>		22d. ADDRESS <b>7620 York Rd., Baltimore, Md. 21204</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>2-14-1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Baltimore, Co. Md.</b>
24. FUNERAL DIRECTOR <b>Lawrence Funeral Home</b>		25a. REC'D BY REGISTRAR <b>FEB 14 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

01882

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01831

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>College Manor</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>7 East Gittings</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Clara Lorena Ferguson</u>				4. DATE OF DEATH Month Day Year <u>February 1, 1966</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 10, 1878</u>	
9. AGE (in years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <u>John Boyd</u>				14. MOTHER'S MAIDEN NAME <u>Sarah E. Johnson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. John H. Ferguson, III</u> Address <u>500 W. University Baltimore, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO (b) <u>Arterio-sclerosis</u> DUE TO (c) <u>?</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u> <u>? yes.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept</u> , 19 <u>54</u> , to <u>Feb 1</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Jan 29, 1966</u> , and that death occurred at <u>9 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Nathan Peterson</u>				22b. DATE SIGNED <u>Feb 1, 1966</u>		22c. ADDRESS	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/8/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>		23d. LOCATION (City or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR <u>Wm. F. Siskner &amp; Sons</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

01883

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01832

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>7709 Hillsway Ave.</b>		d. STREET ADDRESS <b>7709 Hillsway Ave.</b>	
3 NAME OF DECEASED (Type or print) <b>Ellen Frances Fields</b>		4 DATE OF DEATH <b>February 2, 19 66</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>June 26, 1965</b>
9. AGE (In years last birthday) <b>7</b>		IF UNDER 1 YEAR <b>7</b> Months <b>7</b> Days <b>7</b> Hours <b>7</b> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11 BIRTHPLACE (State or foreign country) <b>Maryland Baltimore City</b>		12 COUNTRY OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Robert C. Fields</b>		14 MOTHER'S MAIDEN NAME <b>Eleanor F. Allenbaugh</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16 SOCIAL SECURITY NO. <b>None</b>	
17 INFORMANT <b>Mr. Robert C. Fields</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Gastrointestinal Hemorrhage</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <b>Chronic hepatitis &amp; white liver with obstruction</b> (c) <b>Congenital atresia of the bile ducts.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>about 6 mos.</b> <b>Birth.</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John C. Hyle</b> M.D. EXAMINER'S NAME (Type) <b>JOHN C. Hyle</b>		22. DATE SIGNED <b>2-3-66</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/3/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Cemetery</b>		23d. LOCATION (City or town) (County) (State) <b>Baltimore Co., Maryland</b>	
24 FUNERAL DIRECTOR <b>Leonard J. Ruck Inc. 5305 Harford Rd. #14</b>		25a. REC'D BY REGISTRAR <b>FEB 4 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please move carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

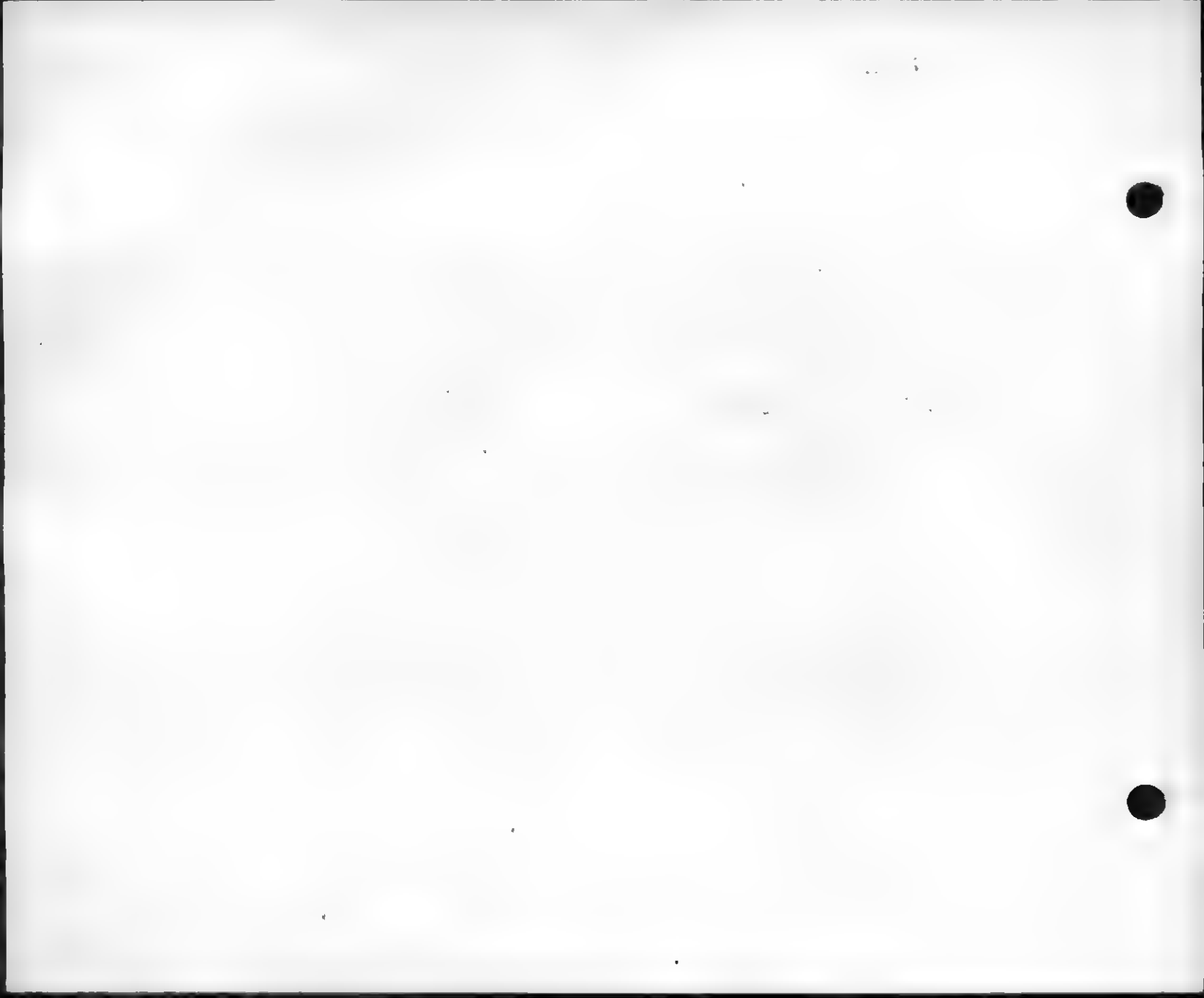
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

01884

01833

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mount Wilson</b> c. LENGTH OF STAY IN b. <b>5 mo</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Mount Wilson State Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rock Creek Park</b> d. STREET ADDRESS <b>None</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>GEORGE WASHINGTON FISHER</b> First Middle Last				4. DATE OF DEATH Month <b>2</b> Day <b>16</b> Year <b>1966</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2.9.1906.</b>	
9. AGE (In years last birthday) <b>60</b> yrs.		10. FUND 1 YEAR <b>Months</b>		11. FUND 24 HRS. <b>Days</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Harbormaster</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Robb Tyler Inc.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>ROBERT FISHER</b>				14. MOTHER'S MAIDEN NAME <b>BESSIE SWIFT</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <b>219-10-5774</b>		17. INFORMANT <b>Hosp. records, Mt. Wilson St. Hospital</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cor pulmonale</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO (b) <b>Far advanced pulmonary tuberculosis</b> DUE TO (c) <b>Pulmonary emphysema.</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b> <b>2 1/2 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pulmonary emphysema.</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED while <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>9.17.1965</b> to <b>2.16.1966</b> that (I) (we) last saw the deceased alive on <b>2.16.1966</b> , and that death occurred at <b>1:40 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Wm. Newcomer</b>				22b. DATE SIGNED <b>2.16.1966</b>		22c. PHYSICIAN'S NAME (Type) <b>Wm. Newcomer, M.D., Superintendent</b>	
22d. ADDRESS <b>Mount Wilson, Maryland</b>				22e. ADDRESS <b>Mount Wilson, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/19/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Magothy Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Magothy, Maryland</b>	
24. FUNERAL DIRECTOR <b>John A. Moran, Inc. 3000 E. Baltimore St.</b>				25a. REC'D BY REGISTRAR <b>FEB 23 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

01885

MD. STATE DEPT. OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01834

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore-rural</b>		c. LENGTH OF STAY IN 1b <b>MARYLAND</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>St. Joseph's</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Md.</b>	
b. COUNTY <b>Baltimore</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore-rural</b>		d. STREET ADDRESS <b>8137 Loch Raven Blvd.</b>	
3. NAME OF DECEASED (Type or print) <b>MARY FISHER</b>		4. DATE OF DEATH <b>2-8-66</b>		5. AGE (In years last birthday) IF UNDER 1 YEAR, IF UNDER 24 HRS. <b>58</b> yrs. Months Days Hours Min.	
6. COLOR OR RACE <b>female white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 5, 1907</b>	
9. SEX <b>female</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Saleslady</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>George R. Ziomek</b>		14. MOTHER'S MAIDEN NAME <b>Lena Bielski</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Andrew Fisher, husband, above</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e.g.)		INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/12/66</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>	
22d. LOCATION (City, town, or country) (State) <b>Baltimore, Md.</b>		23. FUNERAL DIRECTOR <b>Schmunek Funeral Home, Inc.</b> <b>3331 Brehms Lane</b>			
24a. REC'D BY REGISTRAR <b>5 FEB 10 1966</b>		24b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>			

MEDICAL CERTIFICATION



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

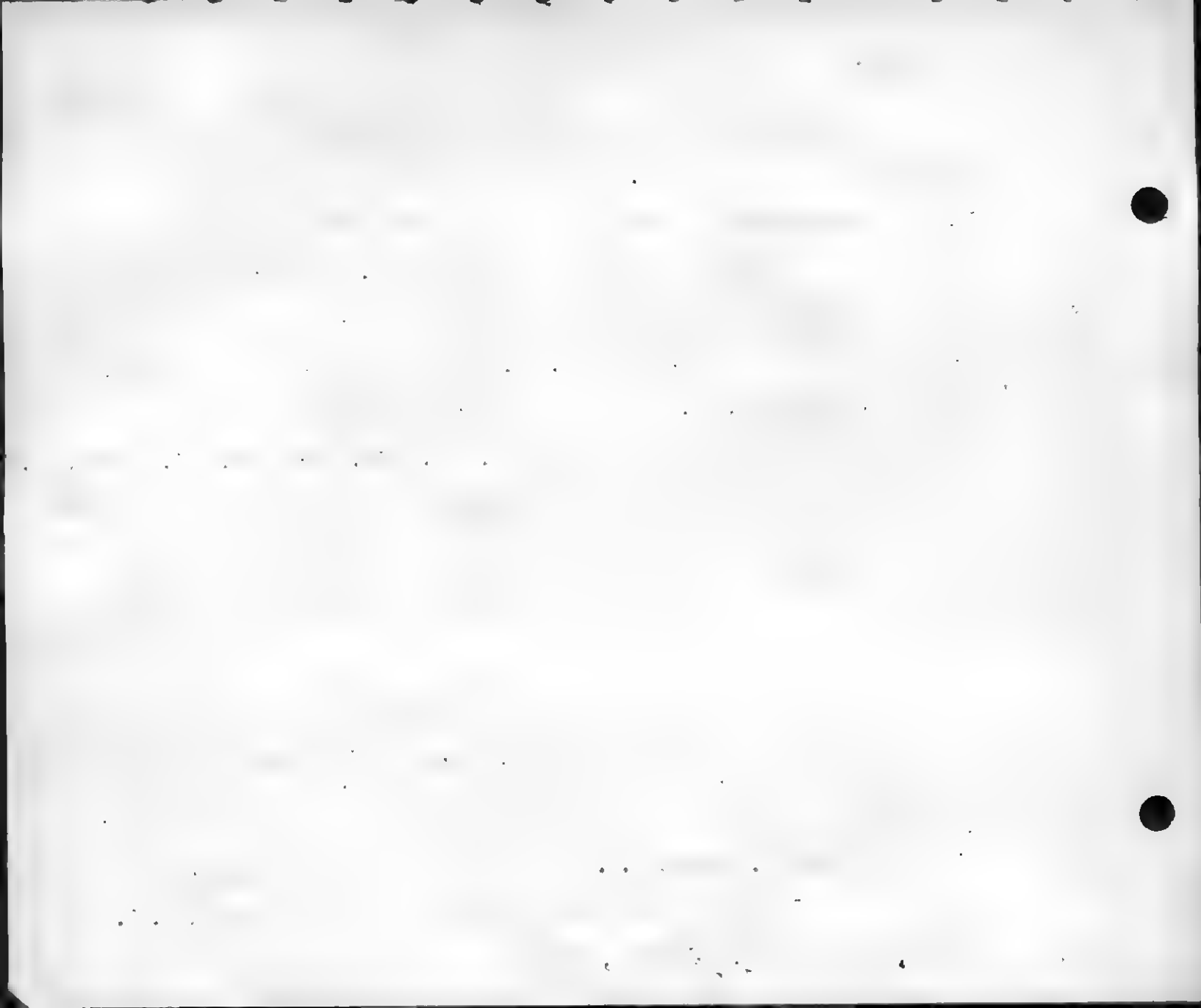
01886

01885

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>10 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>	
3. NAME OF DECEASED (Type or print) First <b>HERBERT</b> Middle <b>BUTLER</b> Last <b>FOOTE, JR.</b>		4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>19</b> Year <b>19 66</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOVEMBER 27, 1918</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>UPHOLSTERER</b>		9b. KIND OF BUSINESS OR INDUSTRY <b>FURNITURE MFG. CO.</b>	9. AGE (In years last birthday) <b>47</b> yrs.
10a. BIRTHPLACE (County & State, or foreign country) <b>GREAT FALLS, SO. CAROLINE</b>		11. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>HERBERT BUTLER FOOTE, SR.</b>		14. MOTHER'S MAIDEN NAME <b>MAY BELLE SCALES</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW-11</b>		16. SOCIAL SECURITY NO. <b>245 05 37 73</b>	
17. INFORMANT <b>CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF THE LIVER</b> <b>1561</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>4 MONTHS</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (if (this hospital) attended the deceased from <b>Feb. 9, 19 66</b> , to <b>Feb. 19, 19 66</b> , that (we) last saw the deceased alive on <b>Feb. 19, 19</b> , and that death occurred at <b>2:30</b> a.m., from the causes and on the date stated above.			
22a. SIGNATURE <i>Louis E. Kimmel</i>		22b. DATE SIGNED <b>2 19 66</b>	
22c. PHYSICIAN'S NAME (Type) <b>LOUIS E. KIMMEL, M.D.</b>		22d. ADDRESS <b>VAH, Fort Howard, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>2/23/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>SUNSET HILLS CEMETERY</b>	23d. LOCATION (City, town or county) (State) <b>GRANITE FALLS, N. C.</b>
24. FUNERAL DIRECTOR <b>JOHNSON, FUNERAL HOME, BALTIMORE, MARYLAND</b>		25a. REC'D BY REGISTRAR <b>FEB 23 1966</b>	
		25b. REGISTRAR'S SIGNATURE <i>W. L. Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please attach carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

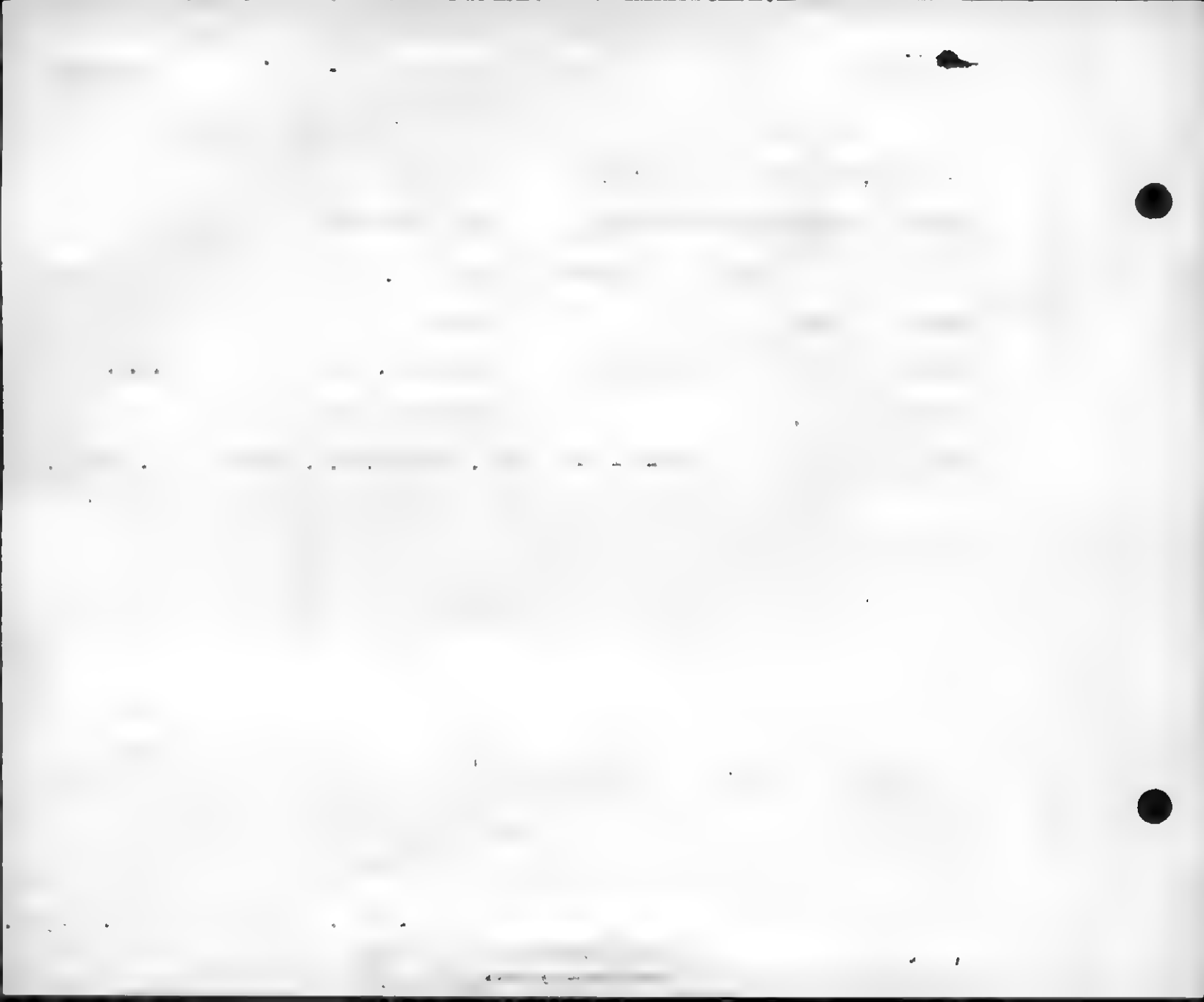
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01887

01836

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard, Maryland</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
c. LENGTH OF STAY IN 1b <b>21 Days</b>		d. STREET ADDRESS <b>5207 York Road</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Elmer</b> Middle <b>Ellsworth</b> Last <b>Ford, Jr.</b>		4. DATE OF DEATH Month <b>2</b> Day <b>28</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/23/96</b>
9. AGE (In years last birthday) yrs <b>69</b>		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B&amp;O Railroad</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>
12. COUNTRY OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Elmer Ford, Sr.</b>	
14. MOTHER'S MAIDEN NAME <b>Estelle Kelley (Stella Kelly)</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW I</b>	
16. SOCIAL SECURITY NO. <b>705-05-23-87</b>		17. INFORMANT <b>CLIN. RECORDS, V.A. HOSPITAL, FT. HOWARD, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARCINOMA OF LUNG WITH METASTASIS</b> 163X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH <b>MONTHS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (this hospital) attended the deceased from <b>2/1</b> , 19 <b>66</b> , to <b>2/28</b> , 19 <b>66</b> , that (we) last saw the deceased alive on <b>2/28</b> , 19 <b>66</b> , and that death occurred at <b>6 A</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>George Dudas</b>		22b. DATE SIGNED <b>2/28/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>GEORGE DUDAS, M. D.</b>		22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>3/3/1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley Mem. Grds. Timonium, Balto. Co., Md.</b>	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR <b>H. W. Jenkins &amp; Sons Company</b>		25a. REC'D BY REGISTRAR <b>MAR 1 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. REGISTRAR'S NAME <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate is signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please refile carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

01883		01837	
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RANDOLPHSTOWN</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Balto. Co. Gen. Hosp.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>807 Wellington Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>H</u> Last <u>Fowler</u>		4. DATE OF DEATH Month <u>2</u> Day <u>9</u> Year <u>1966</u>	
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-11-05</u>	
9. AGE (In years last birthday) <u>60</u> yrs.		10. IF UNDER 1 YEAR: Months <u>6</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>George W. Fowler</u>	
14. MOTHER'S MAIDEN NAME <u>Smith</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hosp. Record</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction - Rupture of Heart</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary atherosclerosis 2° atherosclerosis</u> (c) <u>1001</u> DUE TO <u>1001</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 2</u> , 19 <u>66</u> , to <u>Feb. 9</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Feb. 8</u> , 19 <u>66</u> , and that death occurred at <u>8:15</u> M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Dr. Brannen G. Cadogan</u> M.D.		22b. DATE SIGNED <u>2-9-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>DR. BRANNEN G. CADOGAN</u>		22d. ADDRESS <u>Balto County Gen. Hosp.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2/11/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>LORRAINE PARK</u>		23d. LOCATION (City, town or county) (State) <u>BALTO, MD.</u>	
24. FUNERAL DIRECTOR <u>Paul Chernowicz</u>		25a. REC'D BY REGISTRAR <u>FEB 11 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

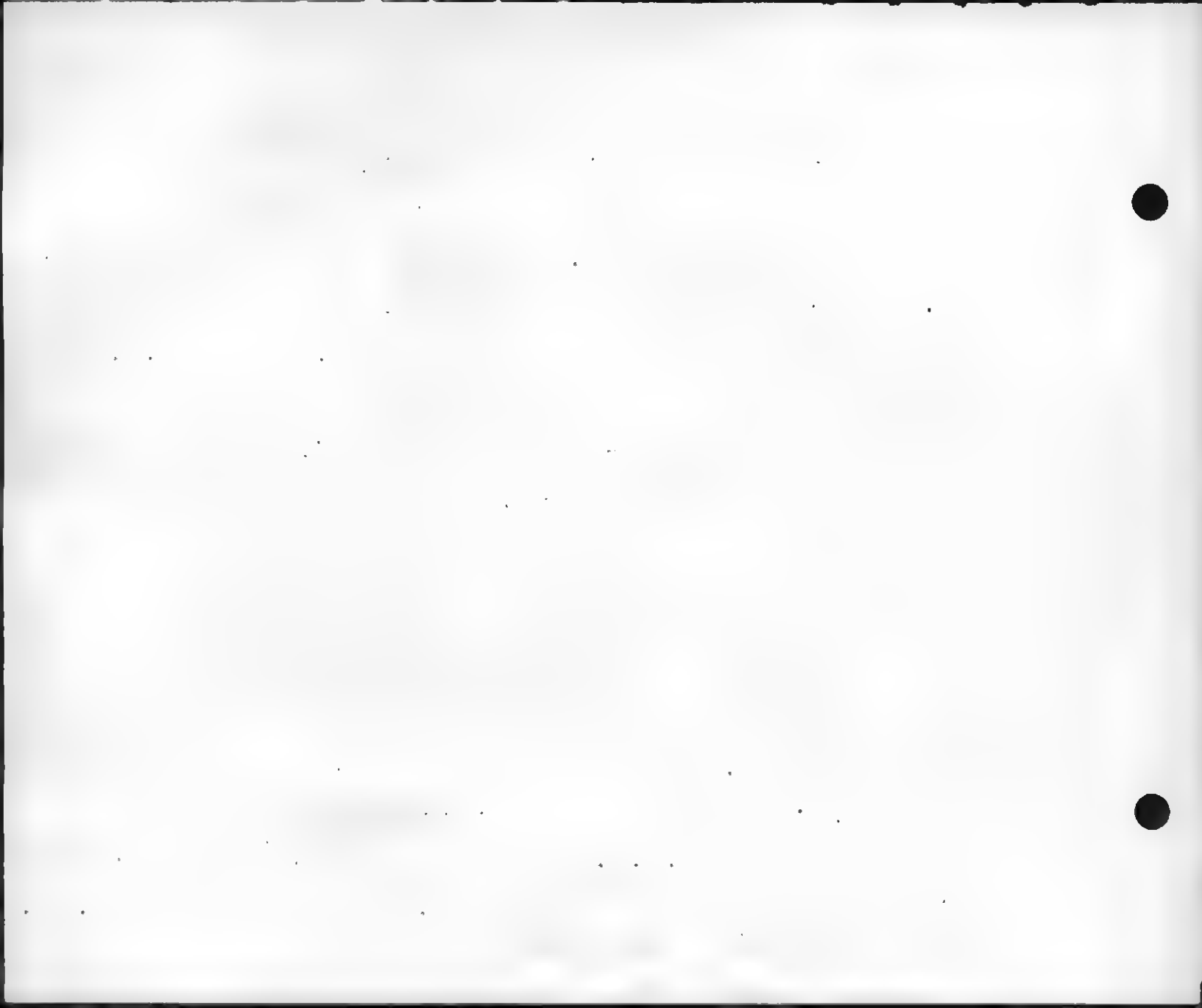
Two for one certificate - Film 6373 - 2/16/68. Mui

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN 1b <b>1yr7mth29dys</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> d. STREET ADDRESS <b>6219 Frederick Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Florence M. Fox</b>			4. DATE OF DEATH Month <b>February</b> Day <b>23</b> Year <b>1966</b>						
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 13, 1888</b>		9. AGE (In years last birthday) <b>77</b> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Jacob Whisner</b>					14. MOTHER'S MAIDEN NAME <b>Isadora Morningstar</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>			16. SOCIAL SECURITY NO. <b>233-50-3774</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>			Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro vascular accident</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>Generalized arteriosclerosis -</b> DUE TO (c) <b>—</b>								INTERVAL BETWEEN ONSET AND DEATH <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>None</b>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (this hospital) attended the deceased from <b>6-24, 1964</b> , to <b>2-23, 1966</b> , that (I) (we) last saw the deceased alive on <b>2-23, 1966</b> , and that death occurred at <b>10 PM</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>George Rodon, M.D.</b>					22b. DATE SIGNED <b>2-23-66</b>				
22c. PHYSICIAN'S NAME (Type) <b>George Rodon, M. D.</b>					22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>2/25/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Stewartstown Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Stewartstown, York Co., Pa.</b>		
24. FUNERAL DIRECTOR <b>Kenneth W. Osburn</b>					ADDRESS <b>Stewartstown Pa.</b>		25a. REC'D BY REGISTRAR <b>FEB 25 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>

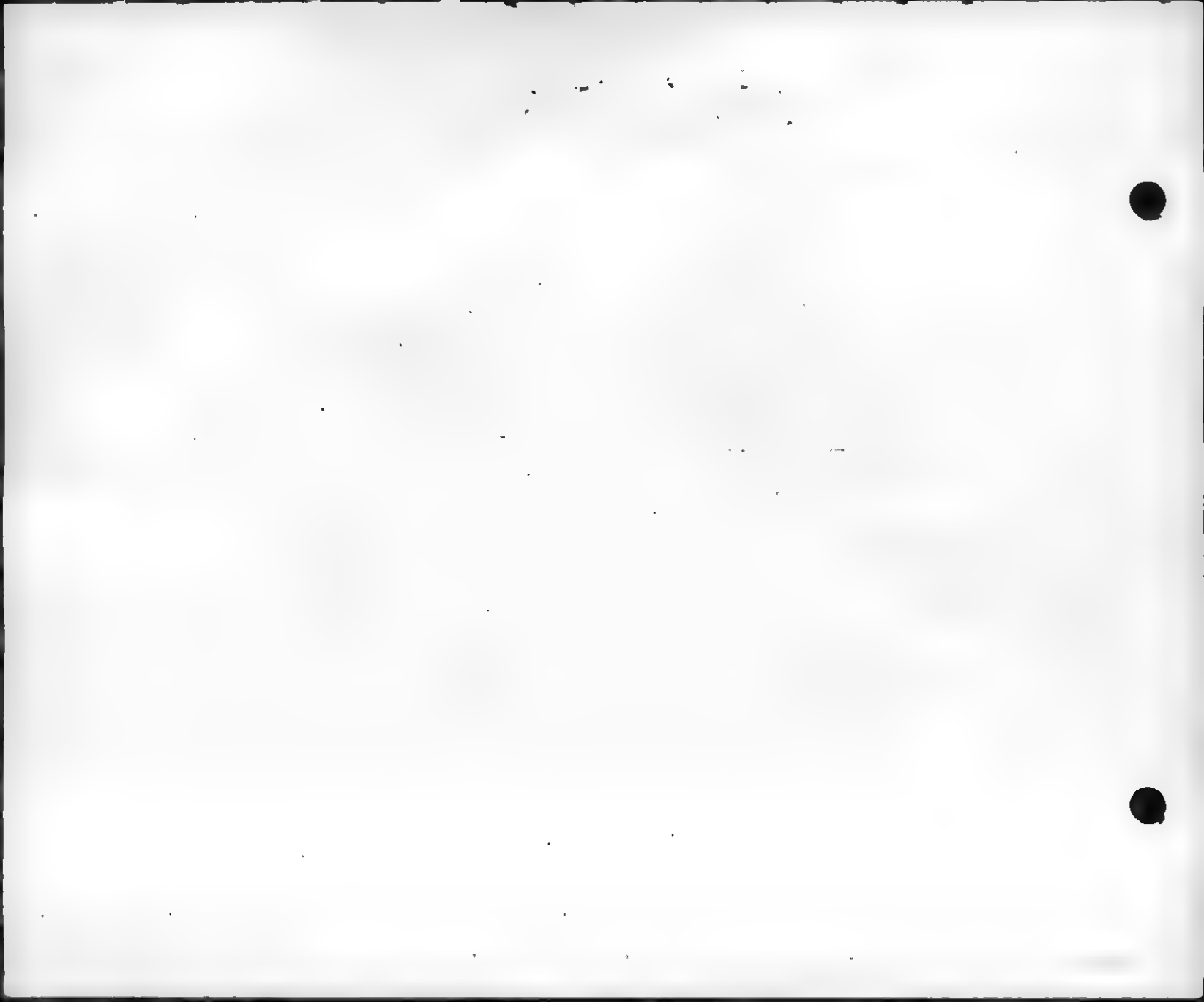


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

01890		01839	
1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> <i>Towson</i> <i>21204</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore County</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Towson</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Greater Baltimore Medical Center</i>		d. STREET ADDRESS <i>7847 Lochwood Rd.</i>	
3. NAME OF DECEASED (Type or print) <i>Infant Boy</i> <i>Freeland</i>		4. DATE OF DEATH Month <i>February</i> Day <i>6</i> Year <i>1966</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>February 6, 1966</i>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9b. KIND OF BUSINESS OR INDUSTRY <i>Infant</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (County & State, or foreign country) <i>GBMC</i> <i>Towson 21204, Md.</i>	
13. FATHER'S NAME <i>James Freeland</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Larverne</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>James Freeland</i>		Address <i>7847 Lochwood Road</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congenital Heart Disease</i> <i>(Transposition of Great Vessels)</i> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
2da. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		2db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
2dc. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	2dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	2de. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	2df. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>3:15 AM/2-6, 1966</i> , to <i>6:45 AM, 1966</i> , that (I) (we) last saw the deceased alive on <i>6:44 AM 2-6-66</i> , and that death occurred at <i>6:45 AM, 2-6-66</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>Mercedes O. Alcantara</i> M.D.		22b. DATE SIGNED <i>2-6-66</i>	
22c. PHYSICIAN'S NAME (Type) <i>MERCEDES O. Alcantara</i>		22d. ADDRESS <i>GBMC; 6701 N Charles St., Towson</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>2-8-66</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Sacred Heart Cemetery</i>	23d. LOCATION (City, town or county) (State) <i>7401 German Hill Rd. Balto. Md.</i>
24. FUNERAL DIRECTOR <i>Charles S. Zeiler</i>		25a. REC'D BY REGISTRAR <i>Feb 11 1966</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

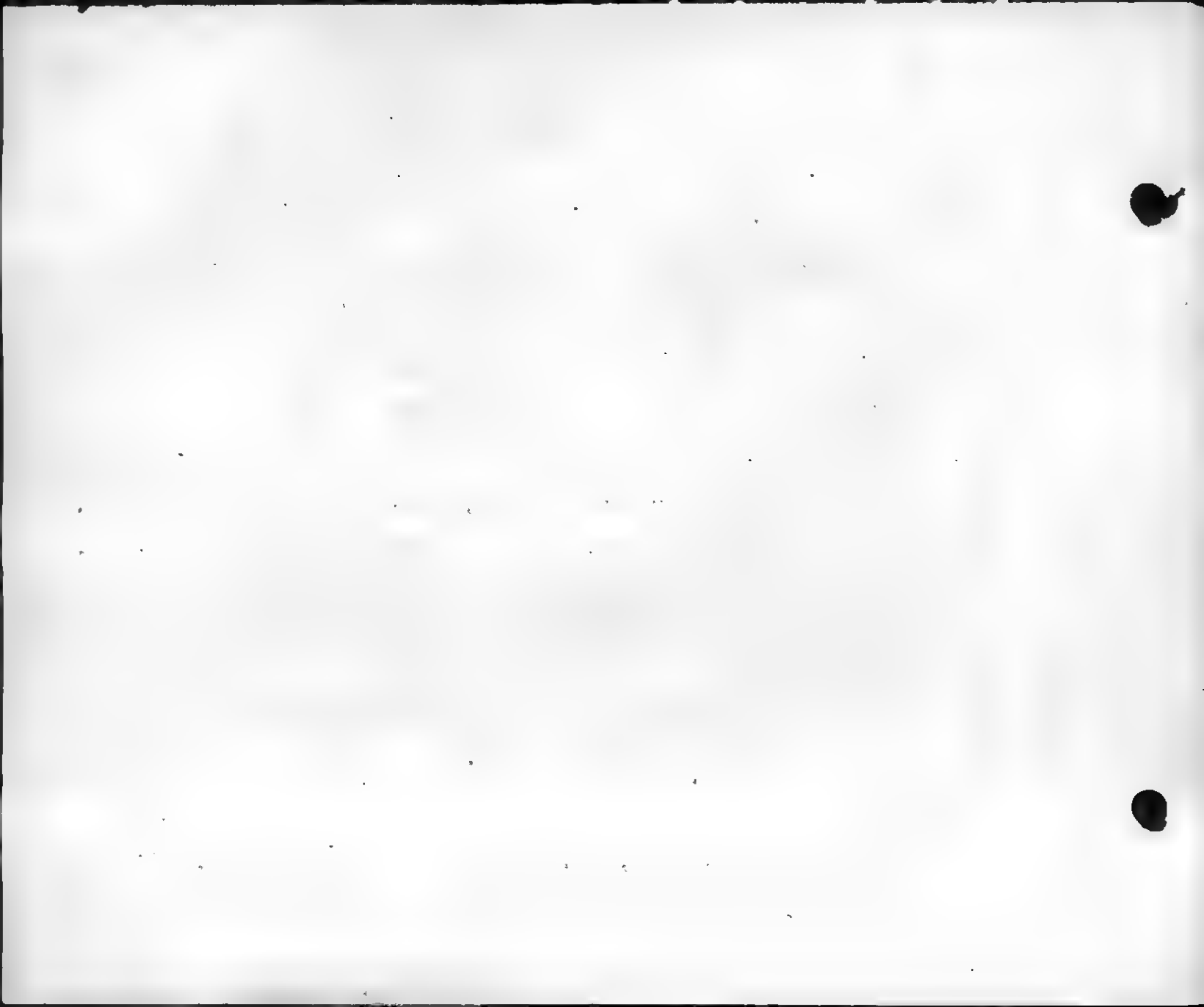
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
01891 CERTIFICATE OF DEATH 01840

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> COUNTY <u>BALTO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>				c. LENGTH OF STAY IN 1b <u>CATONSVILLE</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>108 SMITHWOOD AVE</u>				d. STREET ADDRESS <u>108 SMITHWOOD AVE</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARGARET H. FREELAND</u>				4. DATE OF DEATH Month Day Year <u>FEB 4 1966</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 5, 1905</u>	9. AGE (In years last birthday) <u>61</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TEACHER BALTO. CITY RET.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MP.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MD.</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>THOMAS I. HOOD</u>				14. MOTHER'S MAIDEN NAME <u>MUREL ARNOLD</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>214-40-4439E</u>		17. INFORMANT <u>STABLER FREELAND</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion, acute</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>2 mos.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) the physician attended the deceased from <u>Dec.</u> , 19 <u>53</u> , to <u>Feb.</u> , 19 <u>66</u> , that (I) <u>last</u> saw the deceased alive on <u>Feb. 4</u> , 19 <u>66</u> , and that death occurred at <u>9:30 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Leo J. Gaver, M.D.</u>				22b. DATE SIGNED <u>2/5/66</u>		22c. PHYSICIAN'S NAME (Type) <u>Leo J. Gaver, M.D.</u>	
22d. ADDRESS <u>1 Mallow Hill Ave., Baltimore, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2/8/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>LORRAINE</u>		23d. LOCATION (City, town or county) (State) <u>BALTO CO.</u>	
24. FUNERAL DIRECTOR <u>E. S. MALNABB</u> ADDRESS <u>301 FREDERICK RD 21228</u>				25a. REC'D BY REGISTRAR <u>DATE FEB 9 1966</u>		25b. REGISTRAR'S SIGNATURE <u>John Judge</u>	

MEDICAL CERTIFICATION



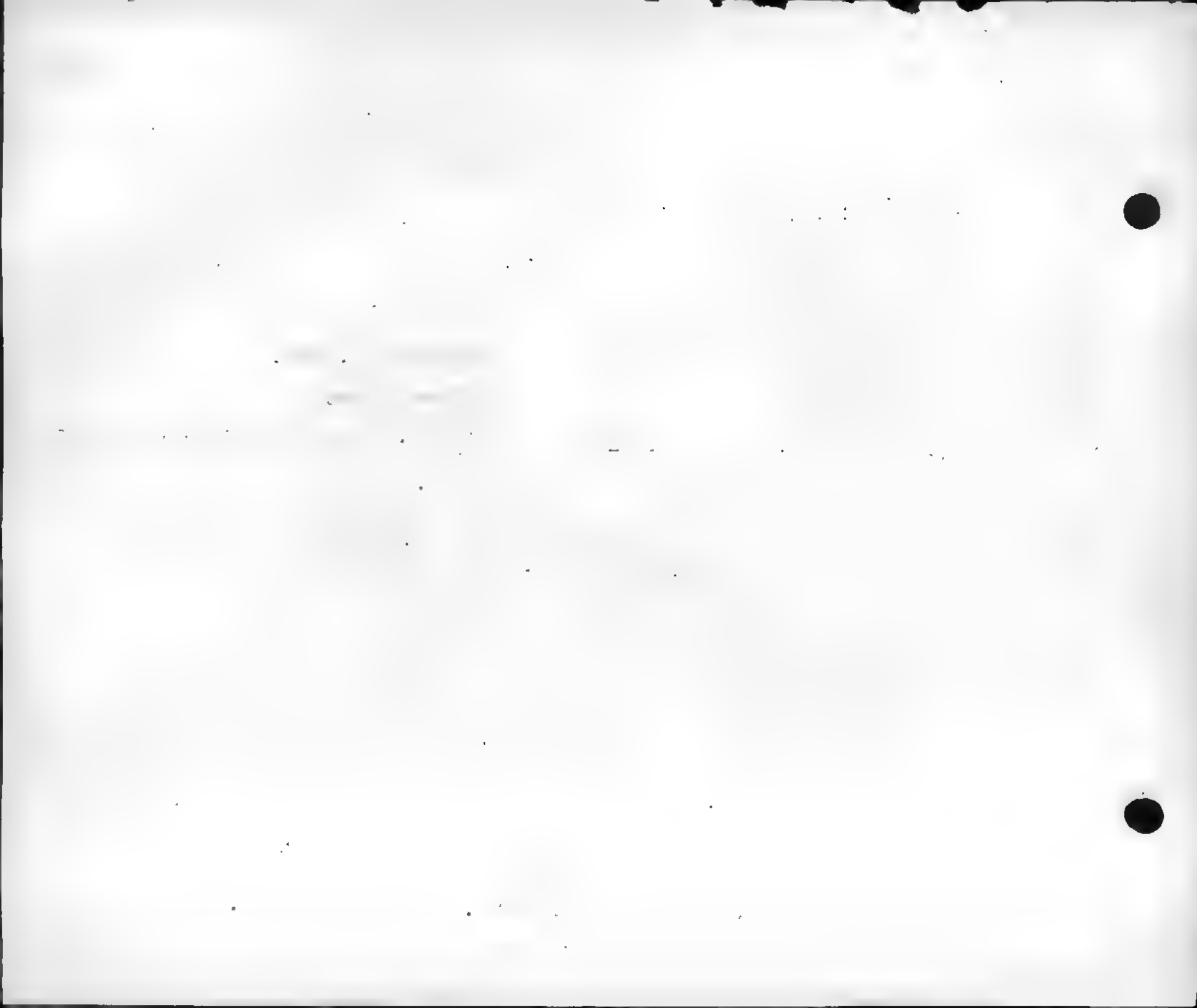
TO HOSPITAL OR ATTENDING PHYSICIAN: The form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MEDICAL CERTIFICATION

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY IN 1b <u>5 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>GREATER BALTIMORE MEDICAL CENTER</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>5-166 Terrace Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) <u>CLARA</u> First Middle Last <b>4. DATE OF DEATH</b> Month <u>2</u> Day <u>18</u> Year <u>1966</u>				<b>5. SEX</b> <u>FEMALE</u> <b>6. COLOR OR RACE</b> <u>WHITE</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>12/27/16</u> <b>9. AGE</b> (In years last birthday) <u>49</u> yrs. <b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>							
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Homemaker</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>At Home</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Stevensville, Maryland</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>				<b>13. FATHER'S NAME</b> <u>Samuel Bullen</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Clara Grimes</u>							
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u> <b>16. SOCIAL SECURITY NO.</b> <u>219-07-7119</u> <b>17. INFORMANT</b> <u>John V. Galicki</u> Address <u>5166 Terrace Dr 21236</u>				<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE PULMONARY EDEMA</u> (b) <u>MULTIPLE PULMONARY EMBOLISM</u> (c) <u>THROMBOPHLEBITIS LEFT LEG</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>  </u>							
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, notify medical examiner) <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>				<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u> 19 <u>66</u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u> <b>20f. (City or town)</b> (County) (State) <u>  </u>				<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>2/13</u> , 19 <u>66</u> , to <u>2/18</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2/18</u> , 19 <u>66</u> , and that death occurred at <u>1130</u> PM, from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <u>Oscar Fernandini</u> <b>22c. PHYSICIAN'S NAME</b> (Type) <u>OSCAR FERNANDINI</u>				<b>22b. DATE SIGNED</b> <u>2/18/66</u> <b>22d. ADDRESS</b> <u>Greater Balto. Med. Center.</u>							
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u> <b>23b. DATE THEREOF</b> <u>Feb 22, 1966</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Holy Rosary Cem.</u> <b>23d. LOCATION</b> (City, town or county) (State) <u>Balto, Md.</u>				<b>24. FUNERAL DIRECTOR</b> <u>Dippel Brothers Inc 7110 Belair Road 21206</u> <b>25a. REC'D BY REGISTRAR</b> <u>Charles Judge</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u> <b>DATE</b> <u>FEB 23 1966</u>							



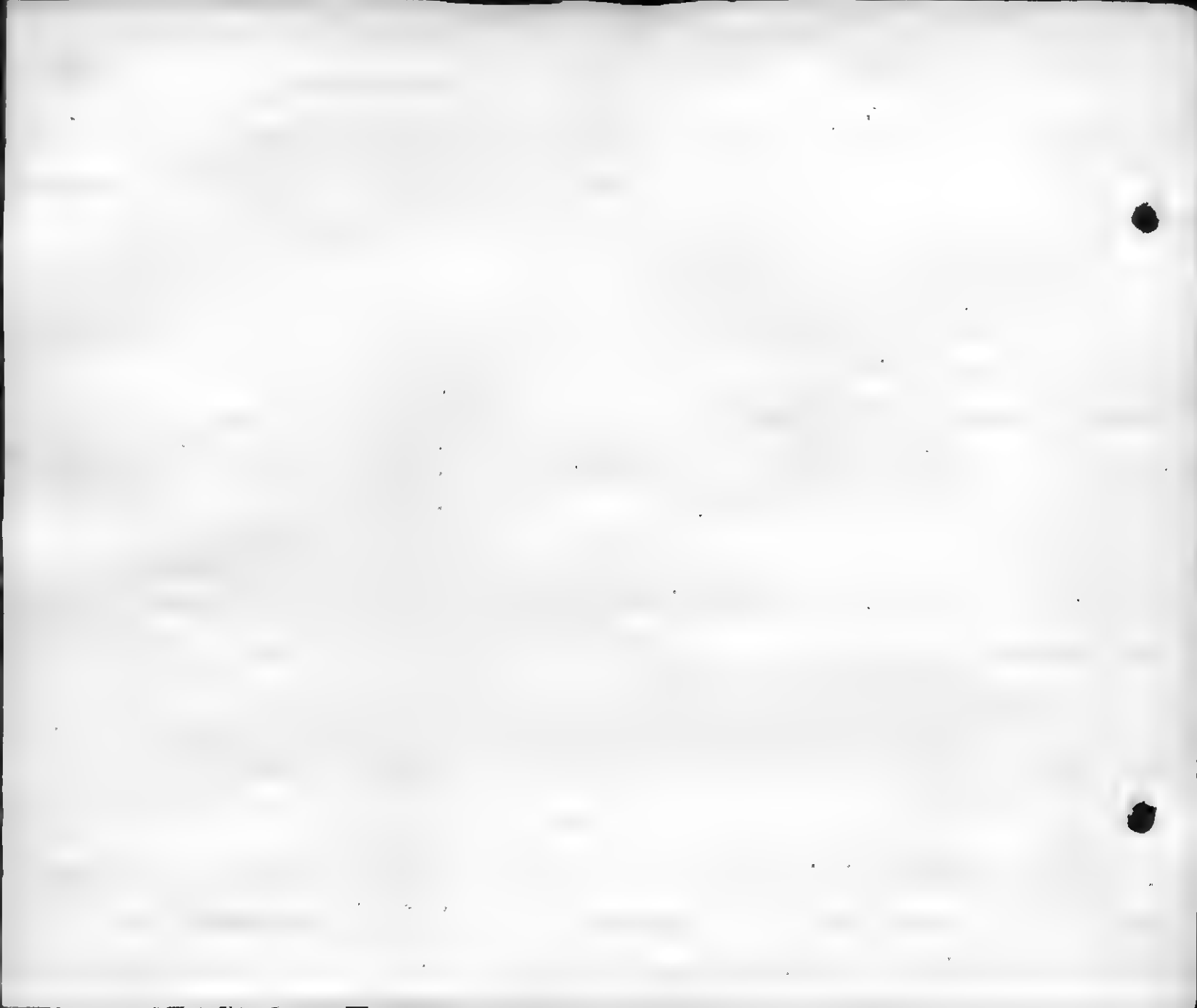
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01893

03341

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OWINGS MILLS</u>		c. LENGTH OF STAY IN IB <u>44 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OWINGS MILLS</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Reisterstown Rd.</u>				d. STREET ADDRESS <u>1115 REISTERSTOWN RD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>C. LARA FRANCES GARRISH</u>				4. DATE OF DEATH Month Day Year <u>2-25-1966</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 19 1898</u>	9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>BALTO., MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>FREDERICK POWNS</u>				14. MOTHER'S MAIDEN NAME <u>CHARA GUNPLIN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213-05-9148</u>		17. INFORMANT <u>Mr. Fred Garrison</u> Address <u>2031 W. 11th St.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Fractured rt. humerus; Fract. rt. radius;</u> DUE TO <u>Fract. ribs right &amp; left; Compound fract. rt. leg</u> (b) <u>(middle 1/3) tibia &amp; fibula; 8" laceration at</u> DUE TO <u>fracture site; 8" laceration rt. popliteal space;</u> (c) <u>Fract. rt. ankle both bones; Fract. rt. femur</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Crossing Reist. Rd., Struck by car</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 min (est)</u>
20c. TIME OF INJURY Month, Day, Year <u>Feb. 25 1966</u> Hour <u>7:10</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>Reisterstown Rd.</u>		20f. (City or town) (County) (State) <u>Owings Mills Balto. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>D. D. Caples</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>D. D. Caples, M. D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
ADDRESS <u>6 Hanover Rd. Reisterstown, Md.</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>MARCH 1-1966</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pleasant Hill, Md.</u>	
23. FUNERAL DIRECTOR <u>Frank H. Newell, Pikeville Rd.</u>				24. REGISTRAR'S SIGNATURE <u>John J. Jones</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These please receive separate carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

01894

<p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>Baltimore Co.</u> MARYLAND</p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u></p> <p>c. LENGTH OF STAY IN b. <u>1</u></p>				<p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</p> <p>a. STATE <u>MD</u></p> <p>b. COUNTY <u>BALTO.</u></p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTO. MD.</u></p> <p>d. STREET ADDRESS <u></u></p> <p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>							
<p>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Joseph's Nursing Home</u></p>				<p>3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>K</u> Last <u>Geist</u></p>							
<p>5. SEX <u>Male</u></p>		<p>6. COLOR OR RACE <u>W.C.</u></p>		<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <u>6-5-1883</u></p>		<p>9. AGE (In years last birthday) <u>82</u> yrs.</p>		<p>10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.</p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u></p>				<p>11. BIRTHPLACE (County &amp; State, or foreign country) <u>MD</u></p>				<p>12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u></p>			
<p>13. FATHER'S NAME <u>John K. Geist</u></p>				<p>14. MOTHER'S MAIDEN NAME <u>Elizabeth Geist</u></p>							
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u></u></p>				<p>16. SOCIAL SECURITY NO. <u>216-01-866</u></p>				<p>17. INFORMANT <u>JOHN K. GEIST, BLOFFTON, IND. RR. 4 Box 324</u></p>			
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <u>Myocardial Insufficiency</u></p> <p>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. (b) <u>Arteriosclerosis, severe</u></p> <p>DUE TO (c) <u></u></p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u></p>										<p>INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u></p>	
<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>											
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>										<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>	
<p>20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u></p>				<p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>		<p>20f. (City or town) (County) (State)</p>			
<p>21. I certify that (I) (this hospital) attended the deceased from <u>7-13</u>, 19<u>63</u>, to <u>2-27</u>, 19<u>66</u>, that (I) (we) last saw the deceased alive on <u>2-26</u>, 19<u>66</u>, and that death occurred at <u>5:30</u> M, from the causes and on the date stated above.</p>											
<p>22a. SIGNATURE <u>David L. Miller</u></p>										<p>22b. DATE SIGNED</p>	
<p>22c. PHYSICIAN'S NAME (Type) <u>David L. Miller MD</u></p>				<p>22d. ADDRESS <u>Liason Rd. Lincolnton, Md.</u></p>		<p>22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/></p>		<p>22f. M.D. <input checked="" type="checkbox"/></p>			
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u></p>		<p>23b. DATE THEREOF <u>MAR. 2, 1966</u></p>		<p>23c. NAME OF CEMETERY OR CREMATORY <u>WESLEYAN CAPEL CEM.</u></p>		<p>23d. LOCATION (City, town, or county) (State) <u>HARFORD CO. MD.</u></p>					
<p>24. FUNERAL DIRECTOR <u>R. Madison Mitchell</u></p>				<p>25a. REC'D BY REGISTRAR <u>Charles Judge</u></p>		<p>25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u></p>					
<p>25c. ADDRESS <u>Harford Co. Md.</u></p>				<p>25d. DATE <u>MAR 2 1966</u></p>		<p>25e. SIGNATURE <u>Charles Judge</u></p>					

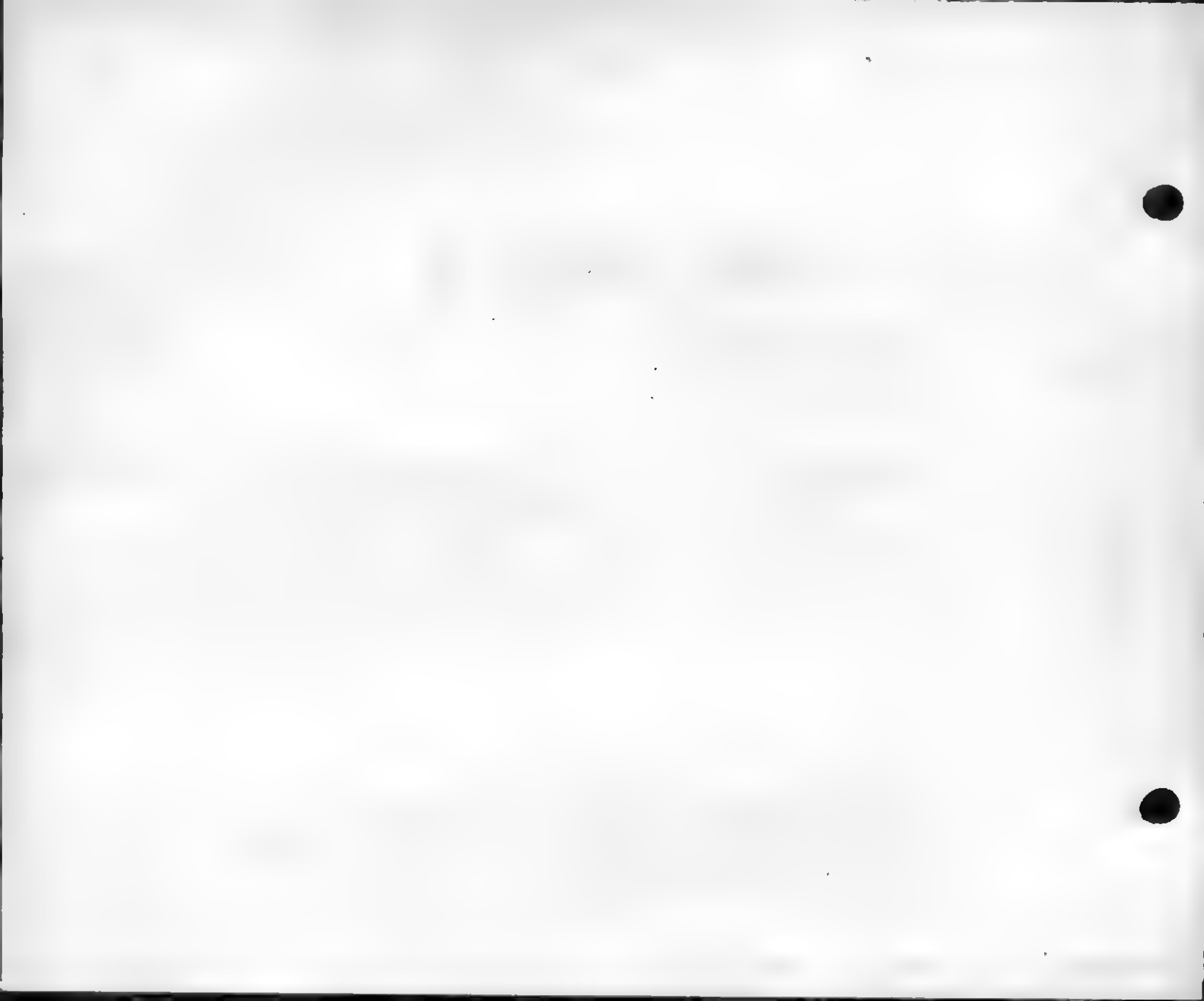


1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
01895 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health on its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Balto</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Hall</u>		c. LENGTH OF STAY IN 1b <u>7 1/2 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>—</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>LAWRENCE ERWIN Gibbs</u>		4. DATE OF DEATH Month Day Year <u>Feb. 14 1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>3/23/1894</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sawmill Operator</u>		9b. AGE (In years last birthday) <u>71</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sawing</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Alonzo S. Gibbs</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-18-9166</u>	
17. INFORMANT <u>Benjamin L. Gibbs</u>		Address <u>542 York Ave. Baltimore, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 4001 DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE <u>P. M. France</u>		22. DATE SIGNED	
EXAMINER'S NAME (Type) <u>A. M. FRANCE</u>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2/17/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Wiseburg Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>White Hall, Md.</u>
24. FUNERAL DIRECTOR <u>S. Jacob Hartenstein, New Freedom Pa.</u>		25a. REC'D BY REGISTRAR <u>DEFB 17 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
01896					CERTIFICATE OF DEATH					01844				
1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>PANTONVILLE</u>					c. LENGTH OF STAY IN 1b <u>27 1/2 months</u>					d. STREET ADDRESS <u>Spring Grove State Hospital</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>BESSIE MAY GIBSON</u>					4. DATE OF DEATH <u>February 20 1966</u>									
5. SEX <u>F.</u>					6. COLOR OR RACE <u>W</u>					7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				
8. DATE OF BIRTH <u>January 20 1889</u>					9. AGE (in years last birthday) <u>77</u> yrs.					10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (County & State, or foreign country) <u>CALVERT County Md.</u>				
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>					13. FATHER'S NAME <u>Samuel J. Gibson</u>					14. MOTHER'S MAIDEN NAME <u>Cecilia F. Gibson</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes give war or dates of service)					16. SOCIAL SECURITY NO. <u>—</u>					17. INFORMANT <u>Records: Spring Grove State Hosp.</u> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Constrictive HEART FAILURE</u> DUE TO (b) <u>PNEUMONITIS</u> DUE TO (c) <u>GENERALIZED ARTERIOSCLEROSIS</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				
20f. (City or town) (County) (State)														
21. I certify that (I) (this hospital) attended the deceased from <u>March 23, 1938</u> to <u>February 20, 1966</u> that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>8:15 A.M.</u> from the causes and on the date stated above.														
22a. SIGNATURE <u>Narciso W. Carmona M.D.</u> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>										22b. DATE SIGNED				
22c. PHYSICIAN'S NAME (Type) <u>NARCISO W. CARMONA</u>										22d. ADDRESS <u>Spring Grove State Hosp.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					23b. DATE THEREOF <u>2-22-66</u>					23c. NAME OF CEMETERY OR CREMATORY <u>Miranda Chr. Cemetery</u>				
23d. LOCATION (City, town or county) (State) <u>Henningtown, Md.</u>					24. FUNERAL DIRECTOR <u>Hutchins Funeral Home</u> ADDRESS <u>OWINGS, MD</u>					25a. REC'D BY REGISTRAR <u>Charles Judge</u> DATE <u>FEB 23 1966</u>				
25b. REGISTRAR'S SIGNATURE														



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

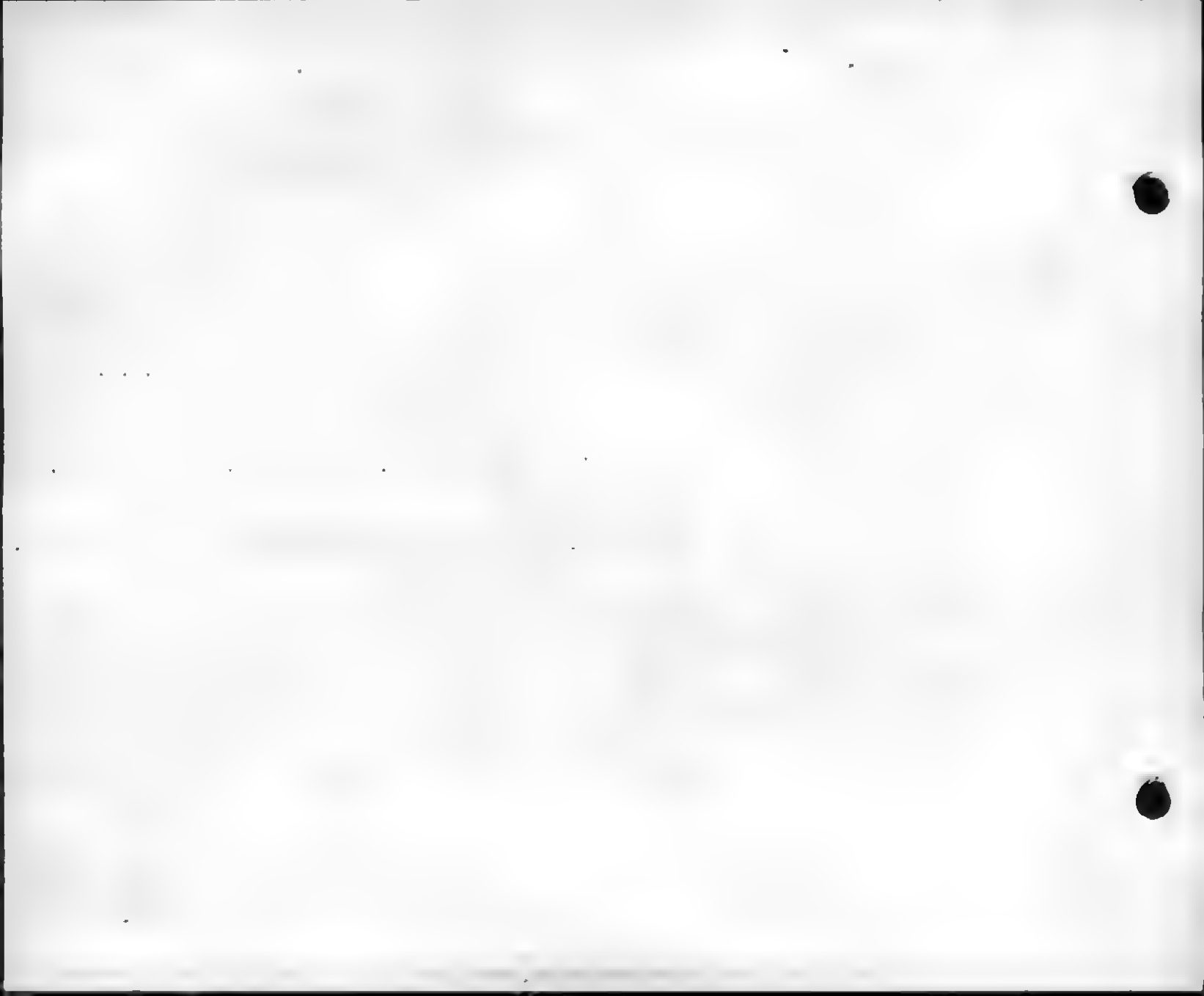
01897

01845

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>20 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		d. STREET ADDRESS <b>BOX 181</b>	
3. NAME OF DECEASED (Type or print) First <b>WARREN</b> Middle <b>H.</b> Last <b>GIFT</b>		4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>25</b> Year <b>19 66</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUGUST 12, 1923</b>
9. AGE (In years last birthday) <b>42 yrs.</b>		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LINE FOREMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Tree Trimming</b>	11. BIRTHPLACE (County & State, or foreign country) <b>PENNSYLVANIA</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>CLYDE GIFT</b>	
14. MOTHER'S MAIDEN NAME <b>LOULLA MN: YOCUM</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW II</b>	
16. SOCIAL SECURITY NO. <b>217 18 7700</b>		17. INFORMANT <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> 151X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CARCINOMA HEAD OF PANCREAS WITH OBSTRUCTIVE JAUNDICE 4 MO.</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>PANCREATIC NECROSIS WITH ABSCESS</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <b>2/5/66</b> , 19 <b>66</b> , to <b>2/25/66</b> , 19 <b>66</b> , that (X) (we) last saw the deceased alive on <b>2/25/66</b> , 19 <b>66</b> , and that death occurred at <b>7:00 AM</b> from causes and on the date stated above.			
22a. SIGNATURE <i>Peter V. Juvan</i>		22b. DATE SIGNED <b>2/25/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>PETER V. JUVAN, M. D.</b>		22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>3/1/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATIONAL</b>	23d. LOCATION (City or Town) (County) (State) <b>ARLINGTON, VIRGINIA</b>
24. FUNERAL DIRECTOR <i>Beverly E. Hopping</i>		25a. REC'D BY REGISTRAR <b>ANNAPOLIS, MARYLAND</b>	
25b. REGISTRAR'S SIGNATURE <i>John G. Judge</i>		25c. DATE <b>MAR 1 1966</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 7-61

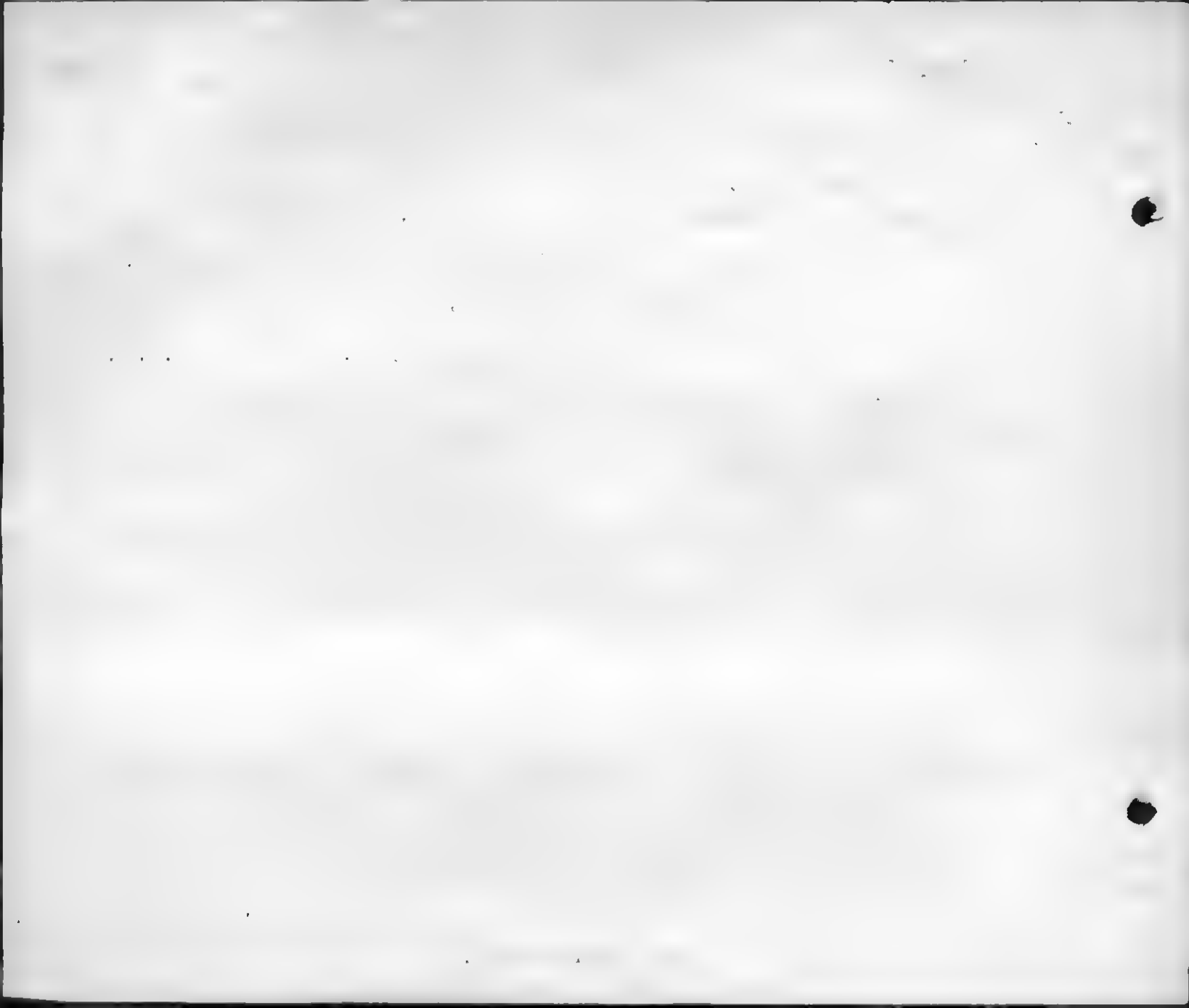
# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

01893

01846

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Towson</b> c. LENGTH OF STAY IN 1b <b>July 1964</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Dulaney Towson Nursing Home</b>		2. USUAL RESIDENCE (Where deceased lived, if institut on. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>2922 St. Paul Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Margaret Huetter Gillen</b> First Middle Last 4. DATE OF DEATH <b>February 2, 1966</b> Month Day Year		5. SEX <b>Female</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>July 20, 1883</b> 9. AGE (In years last birthday) <b>82</b> yrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>Chicago, Ill.</b> 11. BIRTHPLACE (County & State or foreign country) <b>U.S.A.</b> 12. CITIZEN OF WHAT COUNTRY		13. FATHER'S NAME <b>Phillip Huetter</b> 14. MOTHER'S MAIDEN NAME <b>Swedenham</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b> 16. SOCIAL SECURITY NO. <b>None</b> 17. INFORMANT <b>Jean Gillen Smith 7115 Rockridge Road #7</b> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral arteriosclerosis</b> DUE TO (c) <b>Parkinson's Disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Parkinson's Disease</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>11/1/66</b> to <b>2/1/66</b> , that (I) (we) last saw the deceased alive on <b>29 Jan 1966</b> , and that death occurred at <b>11:20 AM</b> , from the causes and on the date stated above. 22a. SIGNATURE <b>Dr. J. E. + 32</b> 22b. DATE SIGNED <b>3-8-66</b> 22c. PHYSICIAN'S NAME (Type) <b>Ellsworth Armacost</b> 22d. ADDRESS <b>Ellsworth Armacost 4600 Liberty Heights Ave.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>2/4/66</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b> 23d. LOCATION (City, town or county) (State) <b>Baltimore, Maryland</b>		24. REC'D BY REGISTRAR <b>F B 4</b> 25. REGISTRAR'S SIGNATURE <b>1966</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

11847

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution. Residence before admittance) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>1 Wk.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>House in the Pines</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville, Manor</b>	
3. NAME OF DECEASED (Type or print) <b>Conrad Gise</b>		4. DATE OF DEATH <b>Feb. 19 1966</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/11/1902</b>
9. AGE (In years last birthday) <b>65</b>		10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Spring Grove</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>219.01.5905</b>	
17. INFORMANT <b>Nellie M. Gise</b>		Address <b>6005 Central Ave. 27</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARCINOMA LYNE</b> -DUE TO- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Metastasis</b> DUE TO (c) <b>3 MOST</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>11/15, 1965</b> to <b>2/19, 1966</b> , that I last saw the deceased alive on <b>2/17, 1966</b> , and that death occurred at <b>10 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Thos E Roach</b>		ADDRESS (Street, city or town, state) <b>5550 B&amp;T NAT? Pine 2/21/66</b>	
PHYSICIAN'S NAME (Type) <b>Thos E Roach</b>		DATE SIGNED <b>B&amp;T M6 21228</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/23/66</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.T. Stansbury</b>		ADDRESS <b>6411 Windsor Mill Rd.</b>	
24a. REC'D BY REGISTRAR <b>23 1966</b>		24b. REGISTRAR'S SIGNATURE <b>J. Stansbury</b>	

TO HOSPITAL OR TENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



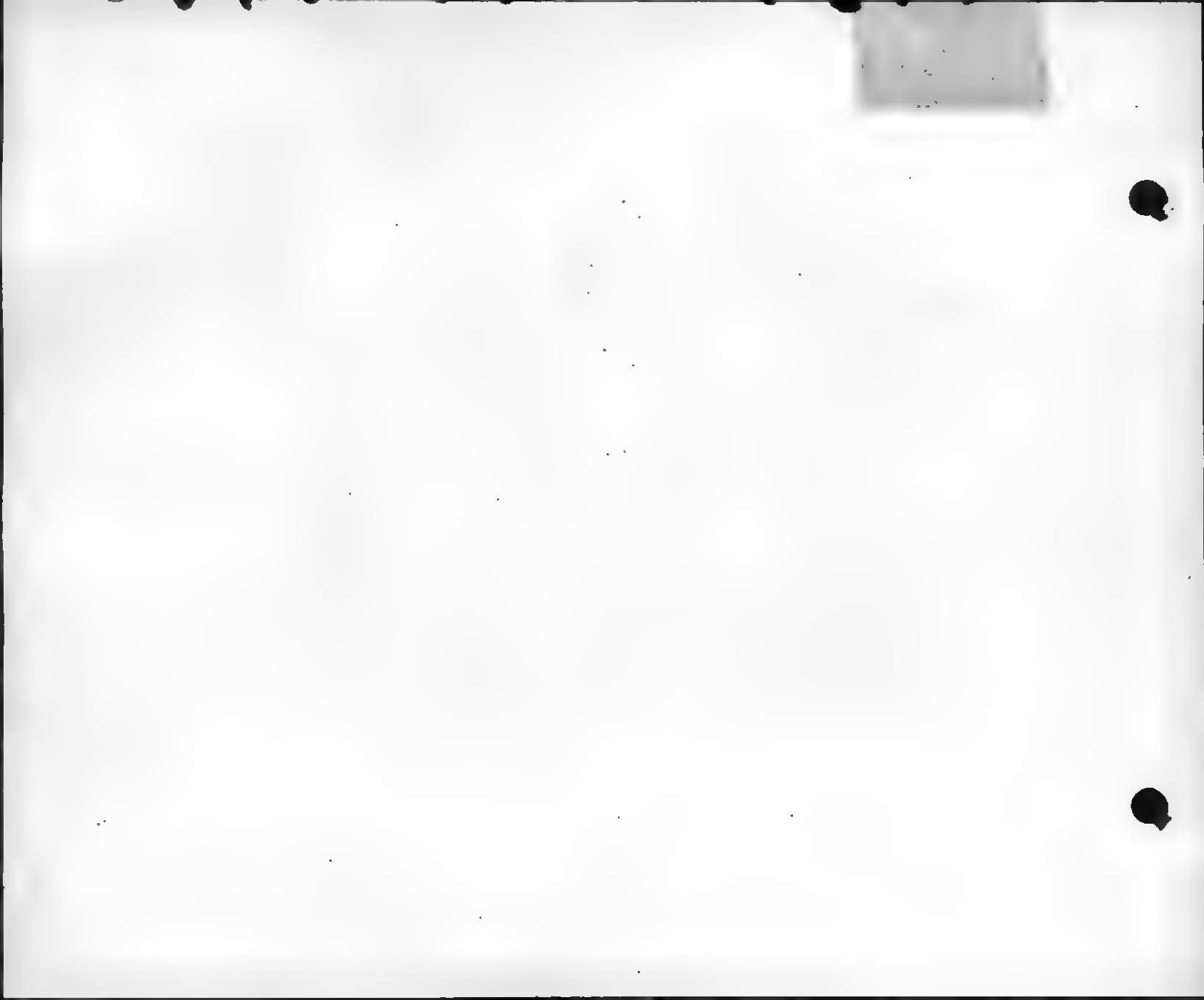
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove margin papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
01900  
CERTIFICATE OF DEATH  
01848

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>	
c. LENGTH OF STAY IN ID <u>7 yrs</u>		d. STREET ADDRESS <u>1313 Sulphur Spring Rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1313 Sulphur Spring Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ludwig Glaser</u>	First Middle Last	4. DATE OF DEATH <u>February 23</u> 19 <u>66</u>	Month Day Year
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 1, 1886</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Blacksmith</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>B. &amp; O. R. R.</u>	
12. BIRTHPLACE (County & State, or foreign country) <u>Lithuania</u>		13. CITIZEN OF WHAT COUNTRY? <u>Lithuanian</u>	
14. FATHER'S NAME <u>Unknown</u>		15. MOTHER'S MAIDEN NAME <u>Unknown</u>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		17. SOCIAL SECURITY NO. <u>705-03-9376</u>	
18. INFORMANT <u>Elsa A. Glaser</u>		Address <u>1313 Sulphur Sp Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the colon</u> 1550 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <u>3-4 months</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>December 1965</u> to <u>Feb 23, 1966</u> , that (I) (we) last saw the deceased alive on <u>Feb 21, 1966</u> , and that death occurred at <u>4:30</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Justin Kudirka</u>		22b. DATE SIGNED <u>2-23-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Justin Kudirka</u>		22d. ADDRESS <u>2151 Wilkens Ave.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2/26/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Immanuel Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>
24. FUNERAL DIRECTOR <u>Ambrose Inc 1328 Sulphur Spring Rd</u>		25a. REC'D BY REGISTRAR <u>FEB 24 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01901

## CERTIFICATE OF DEATH

01849

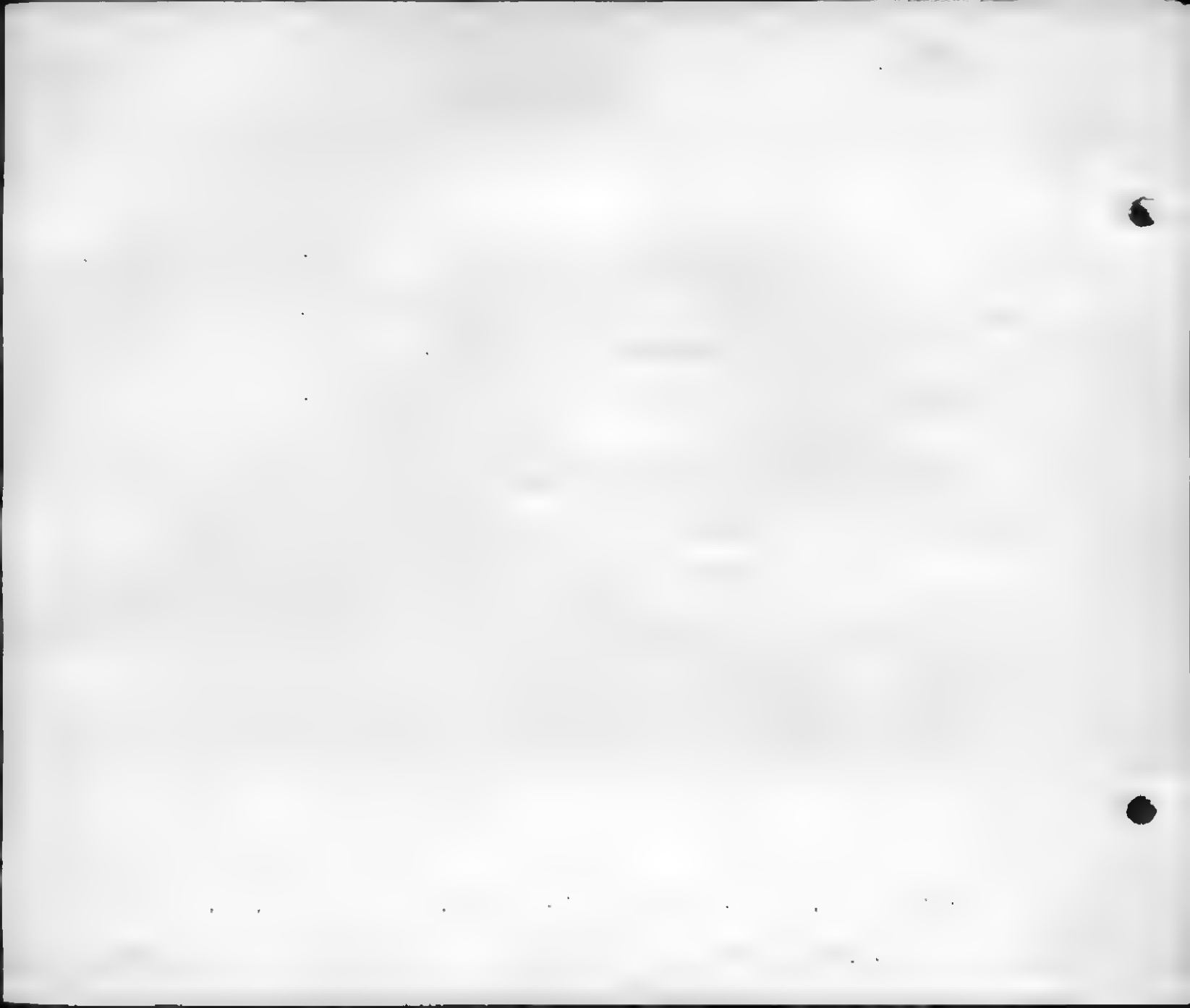
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u> c. LENGTH OF STAY IN b.  d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>269 Colgate Ave.</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u> d. STREET ADDRESS <u>269 Colgate Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>RUBY NANCY GLENN</u> 5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>17 Sept. 1883</u> 9. AGE (In years last birthday) <u>82</u> yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u> 10b. KIND OF BUSINESS OR INDUSTRY  11. BIRTHPLACE (County & State, or foreign country) <u>Illinois</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		4. DATE OF DEATH <u>February 24 1966</u> Month Day Year 13. FATHER'S NAME <u>James Condran</u> 14. MOTHER'S MAIDEN NAME <u>Frances Knapp</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> 16. SOCIAL SECURITY NO.  17. INFORMANT <u>Jessie Kurtz, 269 Colgate Ave. 21222</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Carcinoma of uterus with metastasis to liver, brain, etc.</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>None</u>		INTERVAL BETWEEN ONSET AND DEATH <u>9 mos</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>None</u> 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> 20f. (City or town) (County) (State) <u>Ft. W. Md.</u>		21. I certify that (I) (this hospital) attended the deceased from <u>Feb 24 1966</u> to <u>Feb 24 1966</u> that (I) (we) last saw the deceased alive on <u>Feb 24 1966</u> , and that death occurred at <u>3:10 P.M.</u> from the causes and on the date stated above.	
22a. SIGNATURE <u>M.B. Davis</u> 22c. PHYSICIAN'S NAME (Type) <u>Melvin B. Davis</u>		22b. DATE SIGNED  22d. ADDRESS <u>6800 Morningside Rd.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>2-28-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Baltimore County, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ullrich Funeral Home, Dundalk, Md.</u> ADDRESS		25a. REC'D BY REGISTRAR <u>FEB 28 1966</u> DATE 25b. REGISTRAR'S SIGNATURE <u>John P. Jones</u>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.







# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

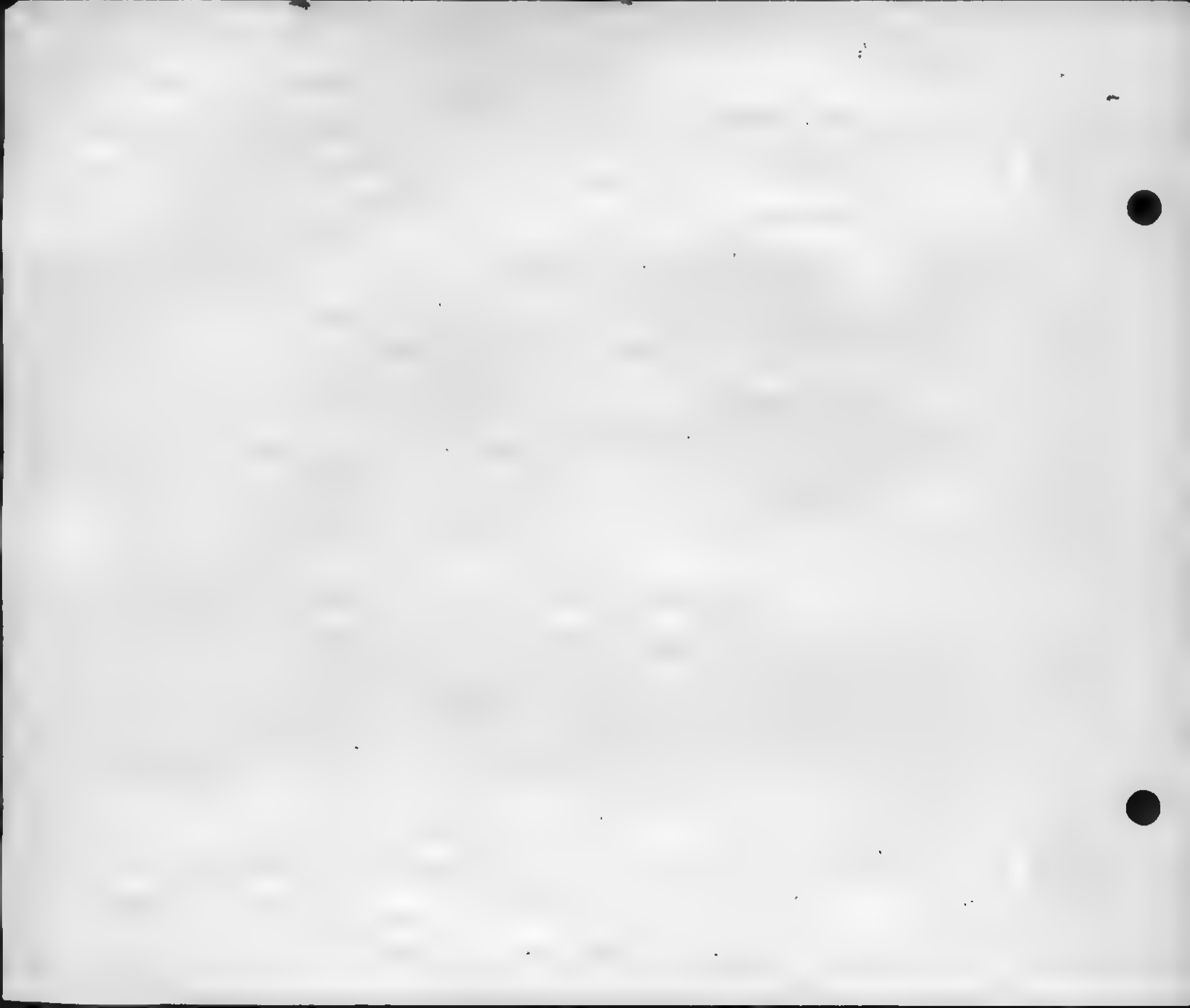
## CERTIFICATE OF DEATH

01903

01851

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

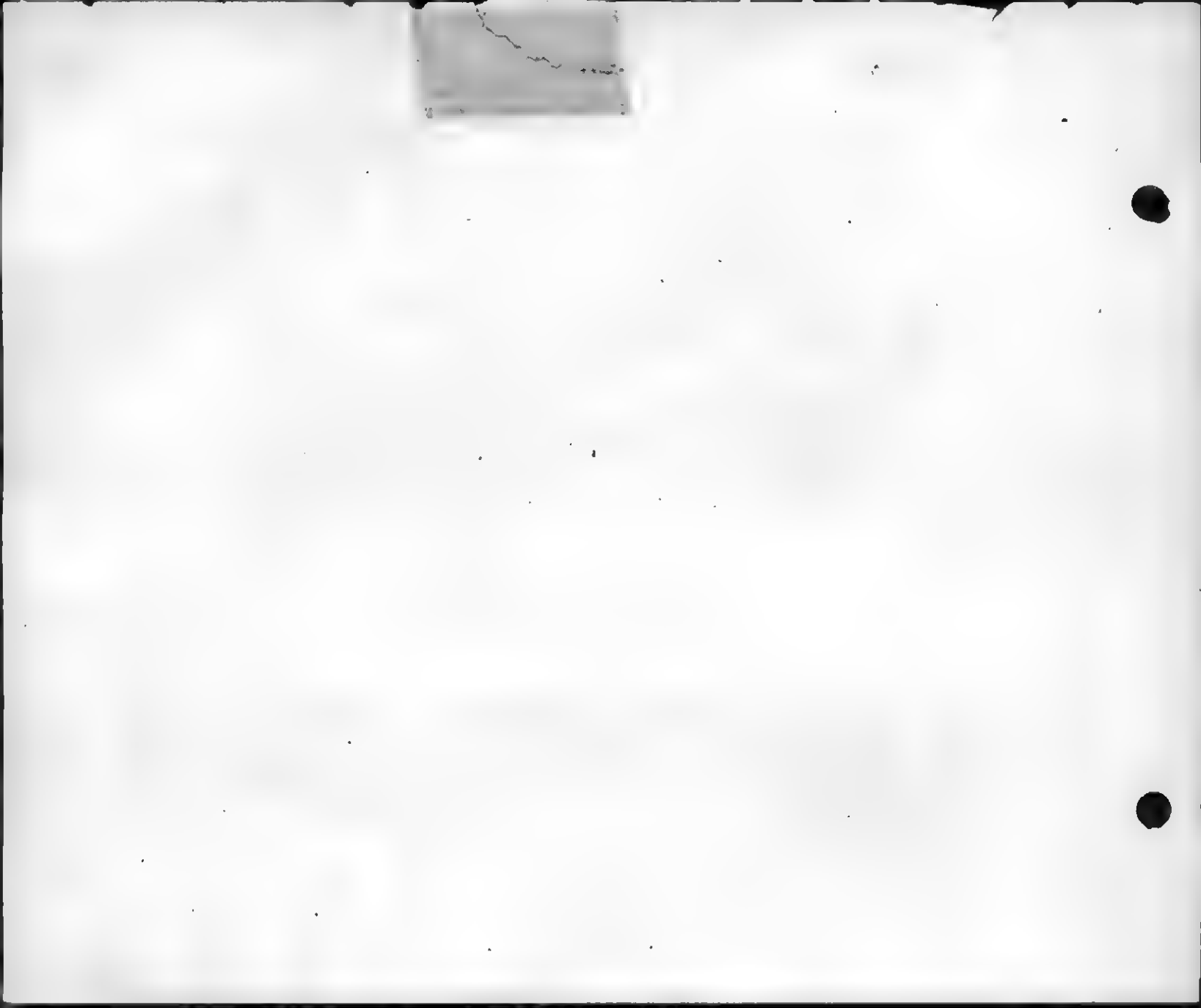
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY IN <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>3402 Kelox Rd</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY _____ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>3402 Kelox Rd</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) <u>XXX FANNY H. GOLDSTEIN</u>		<b>4. DATE OF DEATH</b> <u>2/19/66</u>		9. AGE (In years last birthday) <u>59</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____							
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>8/15/1906</u>		<b>9. WIDOWED</b> <input type="checkbox"/> <b>10. DIVORCED</b> <input type="checkbox"/>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Russia</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>					
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Home</u>				<b>13. FATHER'S NAME</b> <u>Julius Chesses</u>							
<b>14. MOTHER'S MAIDEN NAME</b> <u>Sarah Gerber</u>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <u>no</u>				<b>16. SOCIAL SECURITY NO.</b> <u>218/03/7123</u>				<b>17. INFORMANT</b> <u>Irvin H. Goldstein -- Same</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>metastatic cancer of colon</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (b) _____ (c) _____ DUE TO _____ (e), stating the underlying cause last. _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>5 yrs</u>					
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>															
<b>20. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>															
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. _____				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____		<b>20f. (City or town)</b> _____		<b>(County)</b> _____		<b>(State)</b> _____			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Feb. 11, 1966</u> <b>to</b> <u>Feb. 19, 1966</u> <b>that (I) (we) last saw the deceased alive on</b> <u>Feb. 11, 1966</u> <b>and that death occurred at</b> <u>10M</u> <b>from the causes and on the date stated above.</b>															
<b>22a. SIGNATURE</b> <u>Jonas Cohen</u>										<b>22b. DATE SIGNED</b> <u>Feb. 23 1966</u>					
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Jonas Cohen</u>										<b>22d. ADDRESS</b> <u>6707 Park Heights Ave. Balto 15 Md.</u>					
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>				<b>23b. DATE THEREOF</b> <u>2/20/66</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Chizuk Amuno</u>				<b>23d. LOCATION (City, town or county)</b> <u>Baltimore, Maryland</u>		<b>(State)</b> _____			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>SOL LEVINSON &amp; BROS INC. 6010 Reist Rd.</u>										<b>25a. REC'D BY REGISTRAR</b> <u>Feb 23 1966</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>									
<b>1. PLACE OF DEATH</b> a. COUNTY <i>Baltimore</i> MARYLAND					<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>			c. LENGTH OF STAY IN ID <i>1 1/2 hrs.</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>			d. STREET ADDRESS <i>3525 White Chapel Rd</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Baltimore County General Hosp</i>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
<b>3. NAME OF DECEASED</b> (Type or print) <i>First Daniel Middle Goodman Last</i>			<b>4. DATE OF DEATH</b> Month <i>2</i> - Day <i>19</i> - Year <i>1966</i>		<b>5. SEX</b> <i>M</i>				
<b>6. COLOR OR RACE</b> <i>W</i>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <i>Jan 20, 1907</i>		<b>9. AGE</b> (In years last birthday) <i>59</i> yrs.		<b>10. IF UNDER 1 YEAR</b> Months <i>5</i> Days <i>1</i>	
<b>11a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>Pharmacist</i>			<b>11b. KIND OF BUSINESS OR INDUSTRY</b> <i>Own Store</i>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <i>London, England</i>			<b>12. CITIZEN OF WHAT COUNTRY?</b> <i>USA</i>	
<b>13. FATHER'S NAME</b> <i>JACOB GOODMAN</i>					<b>14. MOTHER'S MAIDEN NAME</b> <i>SARAH ?</i>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown)			<b>16. SOCIAL SECURITY NO.</b> <i>220/14/2826</i>		<b>17. INFORMANT</b> <i>Mrs. Ruth Goodman -- Same</i>			<b>Address</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Generalized metastatic malignant melanoma</i> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)								<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>									
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.)						
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <i>19</i>			<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)		
<b>21. I certify that (I) (this hospital) attended the deceased from <i>2-19</i>, 19<i>66</i>, to <i>2-19</i>, 19<i>66</i>, that (I) (we) last saw the deceased alive on <i>2-19</i>, 19<i>66</i>, and that death occurred at <i>11:55 AM</i> from the causes and on the date stated above.</b>									
<b>22a. SIGNATURE</b> <i>D. Bienvenido A. Cabary M.D.</i>					<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/>		<b>22b. DATE SIGNED</b> <i>2-19-66</i>		
<b>22c. PHYSICIAN'S NAME</b> (Type) <i>D. BIENVENIDO A. CABARY</i>					<b>22d. ADDRESS</b> <i>Baltimore County Gen. Hosp.</i>				
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <i>BURIAL</i>			<b>23b. DATE THEREOF</b> <i>2/20/66</i>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <i>Beth Shalom</i>		<b>23d. LOCATION</b> (City, town or county) (State) <i>Baltimore, Maryland</i>		
<b>24. FUNERAL DIRECTOR</b> <i>SOL LEVINSON &amp; BROS INC. 6010 Reist Rd.</i>					<b>25a. REC'D BY REGISTRAR</b> <b>DATE</b> <i>FEB 23 1966</i>		<b>25b. REGISTRAR'S SIGNATURE</b> <i>[Signature]</i>		



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01905

## CERTIFICATE OF DEATH

01853

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>BALTIMORE</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c. LENGTH OF STAY IN lb <u>Towson</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1216 RIDERVALE ROAD</u>				d. STREET ADDRESS <u>1216 RIDERVALE ROAD</u>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>LOUISE S. GOOSMAN</u>				<b>4. DATE OF DEATH</b> FEB. 18 1966			
<b>5. SEX</b> <u>M</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>JAN. 2, 1895</u>	
<b>9. AGE</b> (In years last birthday) <u>71</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>		<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>	
<b>11b. KIND OF BUSINESS OR INDUSTRY</b> <u>  </u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>GERMANY</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			
<b>13. FATHER'S NAME</b> <u>JOHN JOHAN LEIS</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>JOHN CATHERINE</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)				<b>17. INFORMANT</b> <u>Mrs EDWIN TWELBECK</u> <u>1216 RIDERVALE ROAD</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO <u>170X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>Carcinoma both breasts.</u> DUE TO <u>  </u> (c) <u>  </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.) <u>Shipped + fell on way to Bath room</u>			
<b>20c. TIME OF INJURY</b> Hour <u>9</u> a.m. <u>2-15-1965</u>		<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> at work <input checked="" type="checkbox"/> at home		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>HOME</u>		<b>20f. (City or town) (County) (State)</b> <u>Towson, Balt. Md</u>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>6/3/1965</u> <b>to</b> <u>6/18/1966</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>2/15/1966</u> , <b>and that death occurred at</b> <u>6:30 A.M.</u> <b>from the causes and on the date stated above</b>							
<b>22a. SIGNATURE</b> <u>M. F. QUINN</u>				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>2/18/66</u>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>M. F. QUINN</u>				<b>22d. ADDRESS</b> <u>1927 York Rd, Timonium Md</u>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>		<b>23b. DATE THEREOF</b> <u>FEB. 21/1966</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>LODGE PARK</u>		<b>23d. LOCATION (City, town or county) (State)</b> <u>BALTIMORE, MARYLAND</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Harry H. Witten</u>				<b>ADDRESS</b> <u>4101 EDWARDS RD</u>		<b>25a. REC'D BY REGISTRAR</b> <u>  </u>	
<b>25b. REGISTRAR'S SIGNATURE</b> <u>John J. Judge</u>				<b>DATE</b> <u>FEB 18 1966</u>			

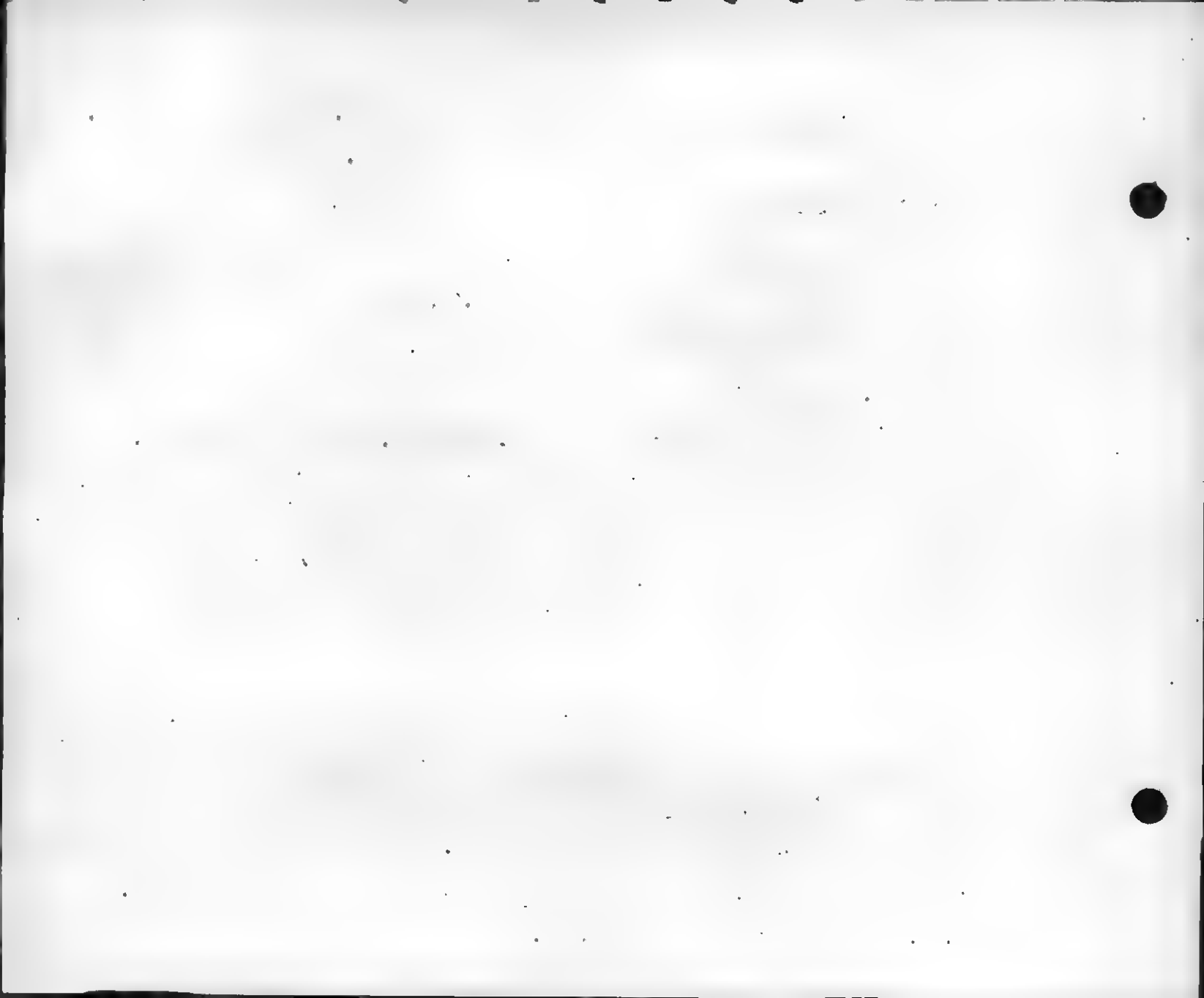


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

01906		01854	
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN 1b <b>11 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Paradise Nursing Home</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hyde, Md.</b> d. STREET ADDRESS <b>Redwood Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Walter L. Gordon</b>		4. DATE OF DEATH <b>Feb 13 19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 21, 1883</b>
9. AGE (In years last birthday) <b>82</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Restaurant Business</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore City</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Thomas W. Gordon</b>	
14. MOTHER'S MAIDEN NAME <b>Margaret Casey</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. Walter M. Gordon</b> Address <b>Hyde, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized Arteriosclerosis</b> DUE TO (b) <b>Chronic Brain Syndrome</b> DUE TO (c) <b>Ulcers Decubitus Multiple</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Dehydration Malnutrition</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs.</b> <b>5 yrs.</b> <b>10 days</b>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>2/2/66</b> to <b>2/13/66</b> , that (I) (we) last saw the deceased alive on <b>2/2/66</b> , and that death occurred <b>Feb 13 1966</b> from the causes and on the date stated above.		22b. DATE SIGNED <b>2/13/66</b>	
22a. SIGNATURE <b>W E McGrath</b>		22c. PHYSICIAN'S NAME (Type) <b>W E McGrath</b>	
22d. ADDRESS <b>1303 Frederick Rd</b>		22e. REC'D BY REGISTRAR <b>2/13/66</b>	
22f. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	
23b. DATE THEREOF <b>2/16/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Reisterstown Methodist</b>	
23d. LOCATION (City, town or county) (State) <b>Reisterstown, Md.</b>		24. FUNERAL DIRECTOR <b>J. F. Eline &amp; Sons</b> ADDRESS <b>Reisterstown, Md.</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

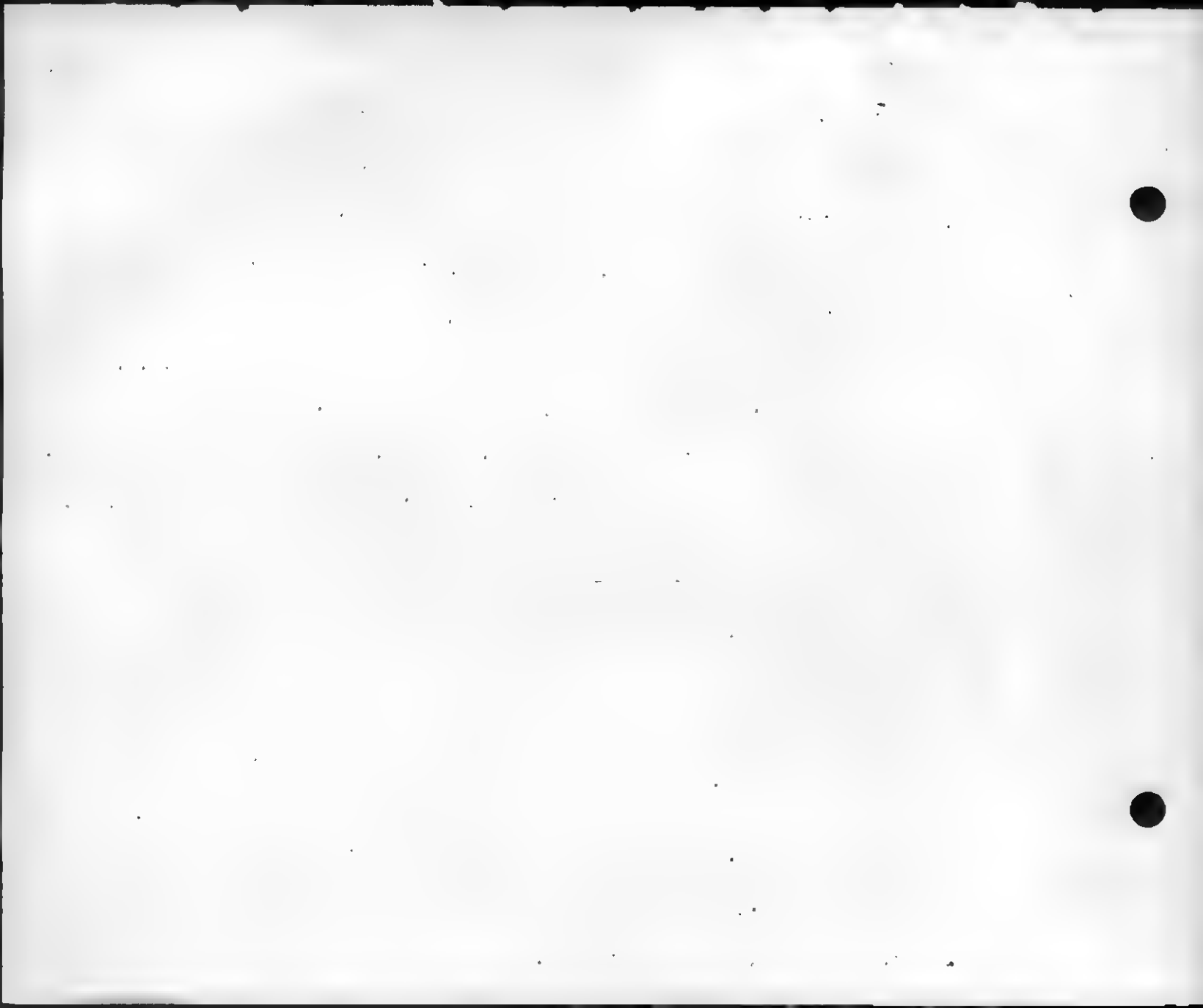
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and page 3 sent, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

01907

01855

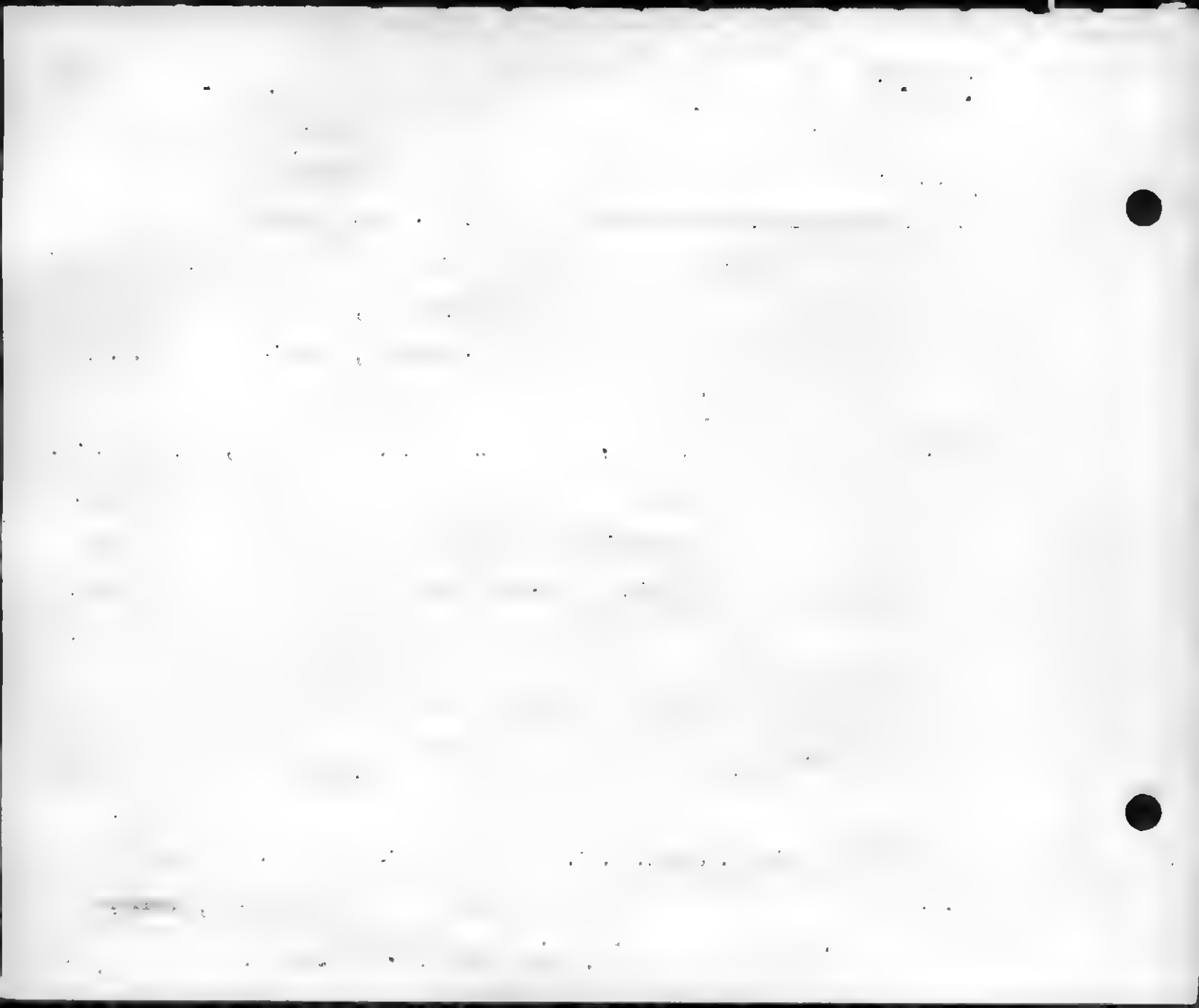
1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>ARBUTUS</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>4708 GATEWAY TERRACE</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>ARBUTUS</b> d. STREET ADDRESS <b>4708 GATEWAY TERRACE 21227</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JOHN J. GRABOWSKI</b>		4. DATE OF DEATH <b>2 9 1966</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>SEPT. 21, 1915</b>
9. AGE (in years last birthday) <b>50</b> yrs.		10. IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>YARD MASTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B &amp; O RAILROAD</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN S. GRABOWSKI</b>		14. MOTHER'S MAIDEN NAME <b>MARY A. DONIECKI</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> (If yes give war or dates of service) <b>WW II</b>		16. SOCIAL SECURITY NO. <b>-----</b>	
17. INFORMANT <b>MRS. MARIE A. WORTMAN, 312 BALTIMORE AVE.</b>		Address <b>#27</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Essential Hypertension</b> DUE TO <b>-----</b> (c) <b>-----</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>2 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Severe gouty arthritis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Feb.</b> , 19 <b>60</b> , to <b>Feb. 9</b> , 1966, that (I) (we) last saw the deceased alive on <b>Feb. 7</b> , 1966, and that death occurred at <b>2 P.</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>James E. Rowe</b>		22b. DATE SIGNED <b>Feb. 10, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>JAMES E. ROWE</b>		22d. ADDRESS <b>5550 BALTIMORE NATIONAL PIKE</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>2/12/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>NEW CATHEDRAL CEMETERY</b>	23d. LOCATION (City, town or county) (State) <b>BALTIMORE, MARYLAND</b>
24. FUNERAL DIRECTOR <b>HUBBARD FUNERAL HOME, 4107 WILKENS AVE. 21229</b>		25a. REC'D BY REGISTRAR <b>Feb 11 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>									
<b>1. PLACE OF DEATH</b> a. COUNTY <b>BALTIMORE</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PORT HOWARD</b> c. LENGTH OF STAY IN 1b <b>33 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>					<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> d. STREET ADDRESS <b>658 W. BARRE STREET</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
<b>3. NAME OF DECEASED</b> (Type or print) First <b>CLARENCE</b> Middle <b>GRAY</b> Last <b>GRAY</b>			<b>4. DATE OF DEATH</b> Month <b>FEBRUARY</b> Day <b>9</b> Year <b>1966</b>		<b>5. SEX</b> <b>MALE</b>			<b>6. COLOR OR RACE</b> <b>NEGRO</b>	
<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>FEBRUARY 14, 1929</b>		<b>9. AGE (In years last birthday)</b> <b>36 yrs.</b>		<b>IF UNDER 1 YEAR</b> Months <b>36</b> Days <b>0</b> Hours <b>0</b> Mins. <b>0</b>		<b>IF UNDER 24 HRS.</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)			<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>BALTIMORE, MARYLAND</b>			<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b>					<b>14. MOTHER'S MAIDEN NAME</b> <b>IZETTA SMITH</b>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>YES</b>			<b>16. SOCIAL SECURITY NO.</b> <b>PL 28 218-22-7818</b>		<b>17. INFORMANT</b> <b>CLIN. RECORDS. VA HOSPITAL, FT HOWARD, MD.</b> Address				
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <b>UREMIA</b> <b>445 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>MALIGNANT HYPERTENSION</b> DUE TO (c) <b>BILATERAL NEPHROSCLEROSIS</b>								<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>RECENT</b> <b>1 YEAR</b> <b>1 YEAR</b>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>									
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)			<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)						
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>			<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)		
<b>21. I certify that (this hospital) attended the deceased from</b> <b>1/7/66</b> , 19 <b>to</b> <b>2/9/66</b> , 19 <b>that (he) last saw the deceased alive on</b> <b>2/9/66</b> , 19 <b>and that death occurred at</b> <b>12:50AM</b> , from the causes and on the date stated above.									
<b>22a. SIGNATURE</b> <i>Peter V. Juvan</i>					<b>22b. DATE SIGNED</b> <b>2/9/66</b>		<b>22c. PHYSICIAN'S NAME (Type)</b> <b>PETER V. JUVAN, M. D.</b>		
<b>22d. ADDRESS</b> <b>VAH FORT HOWARD, MARYLAND</b>					<b>22e. MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/>				
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>BURIAL</b>			<b>23b. DATE THEREOF</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>BALTIMORE NATIONAL</b>		<b>23d. LOCATION (City, town or county)</b> (State) <b>BALTIMORE, MARYLAND</b>		
<b>24. FUNERAL DIRECTOR</b> <b>Charles A. Rice</b>			<b>25a. REC'D BY REGISTRAR</b> <b>Charles A. Rice Funeral Home</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <i>Charles A. Rice</i>				
<b>25c. DATE</b> <b>2/9/66</b>			<b>25d. ADDRESS</b> <b>663 W. Barre Street, Baltimore, Md.</b>						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, if possible, remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

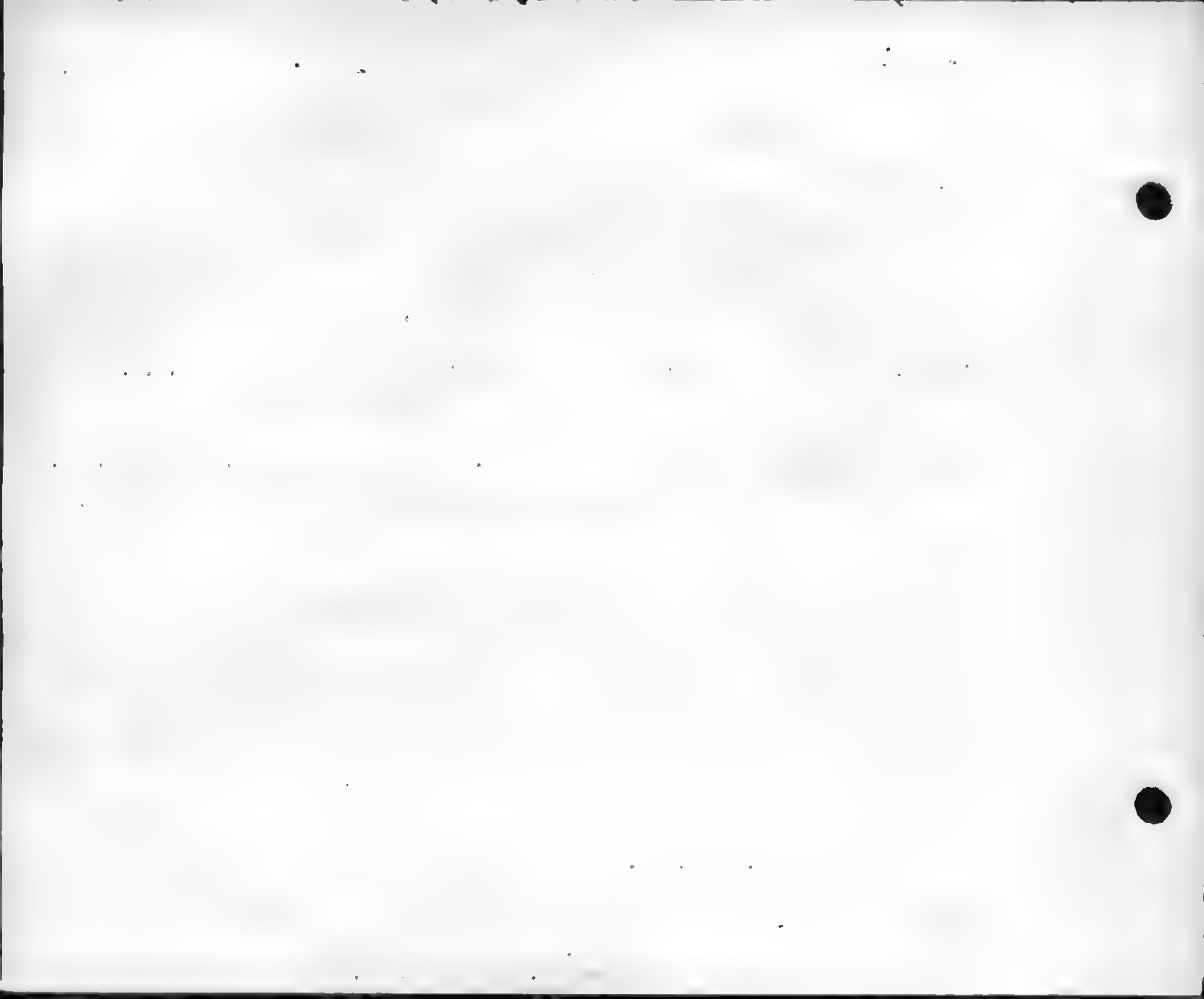
CERTIFICATE OF DEATH

01909

01857

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c LENGTH OF STAY IN 1b <b>91 DAYS</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		e STREET ADDRESS <b>3641 Cottage Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>WILLIE</b> Middle <b>--</b> Last <b>GRAY</b>		4 DATE OF DEATH Month <b>FEBRUARY</b> Day <b>17</b> Year <b>1966</b>	
5 SEX <b>MALE</b>	6 COLOR OR RACE <b>NEGRO</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>MARCH 23, 1893</b>
9 AGE (In years last birthday) <b>72</b> yrs		10 IF UNDER 1 YEAR Months Days Hours Min	
11 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALESMAN</b>		12 KIND OF BUSINESS OR INDUSTRY <b>SEAFOOD</b>	
13 BIRTHPLACE (County & State, or foreign country) <b>COVINGTON, GEORGIA</b>		14 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15 FATHER'S NAME <b>IKE GRAY</b>		16 MOTHER'S MAIDEN NAME <b>MANDY MN: UNKNOWN</b>	
17 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW I</b>		18 SOCIAL SECURITY NO <b>217 22 5368</b>	
19 INFORMANT <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <b>151X IMMEDIATE CAUSE (a) ADENOCARCINOMA OF STOMACH</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>6 MONTHS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f (City or town) (County) (State)
21. I certify that <b>As</b> (this hospital) attended the deceased from <b>11/23/65</b> , 19__, to <b>2/17/66</b> , 19__, that <b>(X) we</b> last saw the deceased alive on <b>2/17/66</b> , 19__, and that death occurred at <b>8:00 PM</b> from causes and on the date stated above.			
22a SIGNATURE <i>Peter V. Juvan</i>		22b DATE SIGNED <b>2/18/66</b>	
22c PHYSICIAN'S NAME (Type) <b>PETER V. JUVAN, M. D</b>		22d ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b DATE THEREOF <b>2-23-66</b>	23c NAME OF CEMETERY OR CREMATORY <b>LOUDEN PARK NATIONAL</b>	23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>
24 FUNERAL DIRECTOR <i>E.O. Wilson</i>		25a REC'D BY REGISTRAR <b>ELROY O. WILSON FUNERAL HOME</b> DATE <b>FEB 23 1966</b>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

VR A15 (4)  
20 M 1/66



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01858

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>W/ Mount Wilson</b> c. LENGTH OF STAY (If in hospital, give street address) <b>21 hours</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Res. dence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Mount Wilson State Hospital</b>		d. STREET ADDRESS <b>1326 North Carey Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ambrose</b> Middle <b>Green</b> Last <b>Green</b>		4. DATE OF DEATH Month <b>February</b> Day <b>3</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Non-white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/21/86</b>
9. AGE (In years and birth day) <b>79</b>		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>19</b> Hours <b>19</b> Min <b>19</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Richard Green</b>		14. MOTHER'S MAIDEN NAME <b>Louisa Colbert</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>No</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO <b>Medical Records, Mt. Wilson St. Hosp.</b>	
17. INFORMANT <b>Medical Records, Mt. Wilson St. Hosp.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pneumonia, right side</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic alcoholism</b> DUE TO (c) <b>Chronic alcoholism</b>		INTERVAL BETWEEN ONSET AND DEATH <b>two weeks</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic alcoholism</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day Year Hour a.m. <b>None</b> p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>None</b>		20f. (City or town) (County) (State) <b>None</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>D. D. Caples</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>D.D. Caples, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county)	
22. DATE SIGNED <b>2/3/66</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-7-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Not Auburn Cem</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore Md</b>	
24. FUNERAL DIRECTOR <b>George A. Hlon 1348 N. Calhoun St.</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
		DATE <b>2-7-1966</b>	



**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

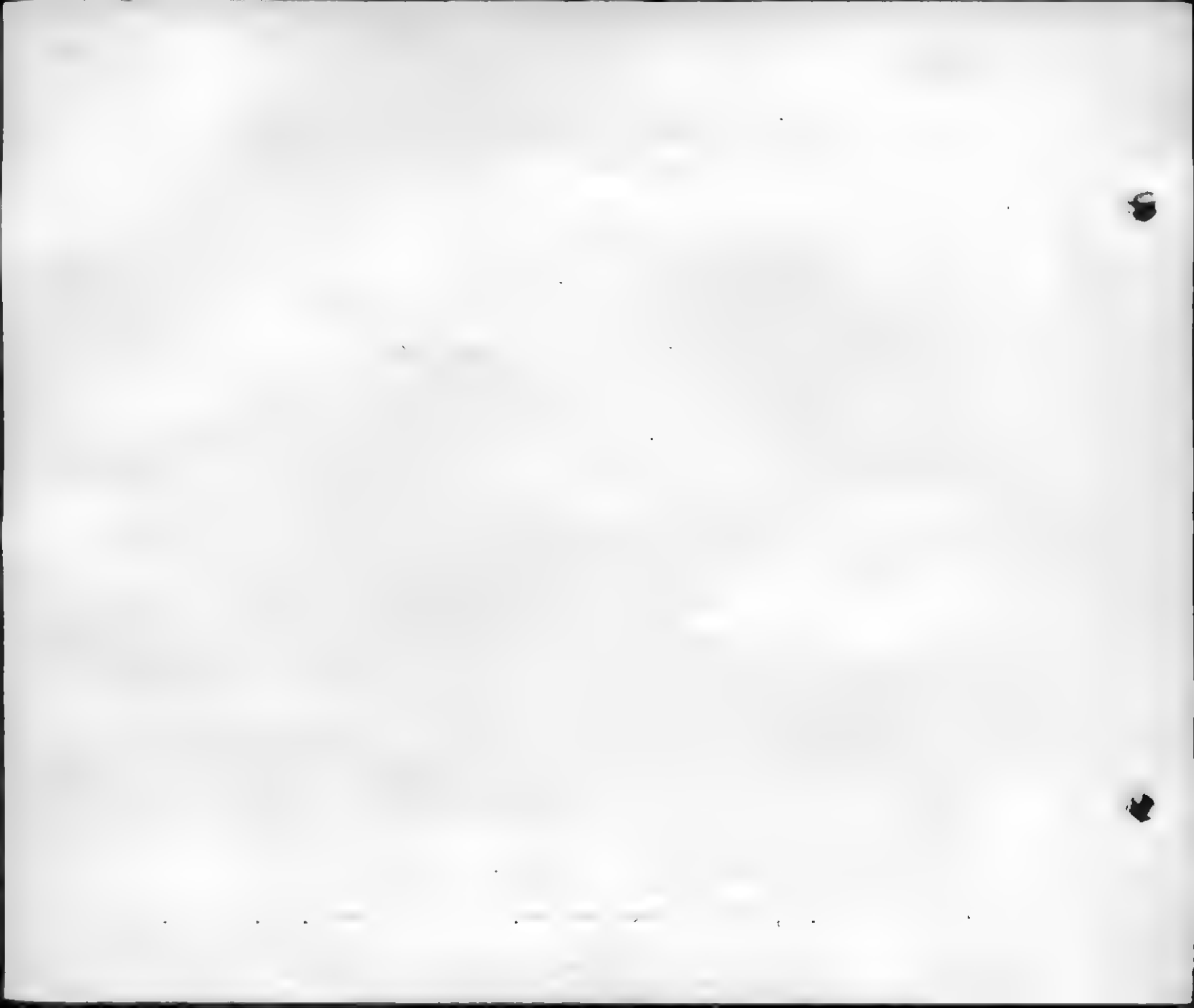
01859

01911

1 PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> <u>GO</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>			
c. LENGTH OF STAY IN 1b <u>16 mo. 10 mo.</u>				d. STREET ADDRESS <u>3703 Forest PARK Ave</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PICKERS Gilt Aged Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last <u>LAURA FLORENCE GREEN</u>				4. DATE OF DEATH Month Day Year <u>Feb 2 1966</u>			
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>3-12-1880</u>		9 AGE (In years last birthday) <u>85</u> yrs	IF UNDER 1 YEAR Months Days Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SEAMSTRESS</u>		10b KIND OF BUSINESS OR INDUSTRY <u>DRESSMAKING</u>		11. BIRTHPLACE (State or foreign country) <u>Not Known</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>EDWIN F GREEN</u>				14. MOTHER'S MAIDEN NAME <u>E E WOOLFORD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>219-10-5310A</u>		17. INFORMANT <u>Katherine M Young R N</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO (b) <u>ASCVD</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (c) <u>years</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 7 1949</u> to <u>Feb 2 1966</u> , that (I) (we) last saw the deceased alive on <u>Feb 1 1966</u> , and that death occurred at <u>8:30 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Newland E Day</u> M. D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>NEWLAND E. DAY</u>				22d. ADDRESS <u>4-E-33rd St Baltimore 18 MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb. 4, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Balto. Co. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>WM. COOK-BROOKS TOWSON</u> ADDRESS <u>1050 YORK RD TOWSON, MARYLAND 21204</u>				25a. REC'D BY REGISTRAR <u>FEB 7 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any case within 72 hours after death.

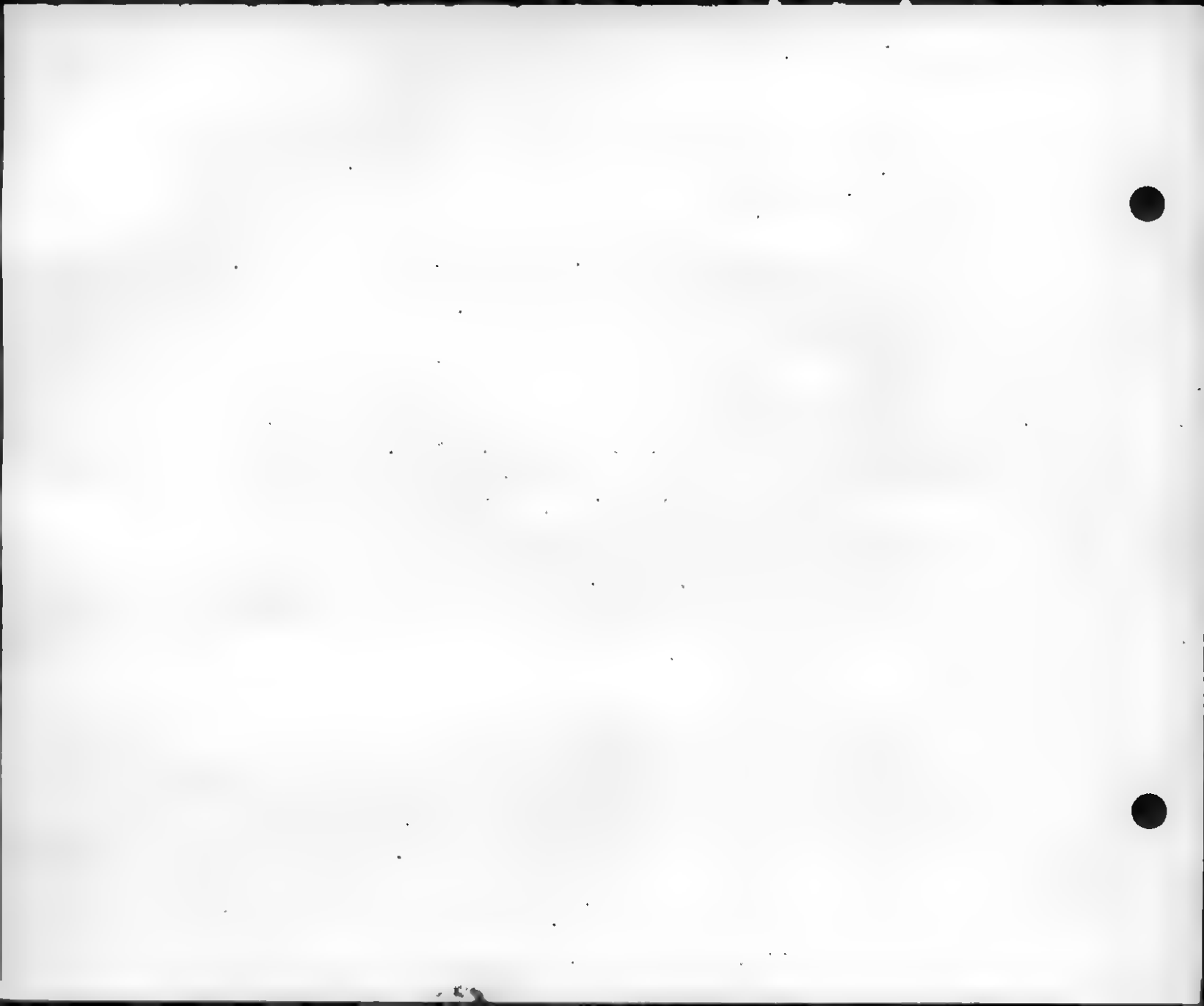


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be received within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>						c. LENGTH OF STAY IN 1b <u>5-4</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>531 Stevenson Lane Holly Hill Manor Nursing Home</u>						d. STREET ADDRESS <u>4413 Croveland Avenue</u>					
3. NAME OF DECEASED (Type or print) First <u>Nellie</u> Middle <u>A.</u> Last <u>Gressitt</u>						4. DATE OF DEATH <u>Feb. 5, 1966</u> 19 <u>19</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 6, 1883</u>		9. AGE (in years last birthday) <u>82</u> yrs.		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>York, Pennsylvania</u>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>? Prentiss</u>						14. MOTHER'S MAIDEN NAME <u>Emma ?</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes give war or dates of service)</u>				16. SOCIAL SECURITY NO. <u>215-30-0581</u>		17. INFORMANT <u>Mrs. John B. Lang</u>		1300 Summit Ave. Address.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the lungs</u> 194X DUE TO <u>to both lungs</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>Smoking</u> (b) <u>Smoking</u> (c) <u>Smoking</u>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 600</u> , 19 <u>66</u> , to <u>Feb 5</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Richard Byerly</u>						M.O. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>M. Paul Byerly</u>						22d. ADDRESS <u>56 W. York Rd. Baltimore</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>2/8/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Woodlawn, Md.</u>			
24. FUNERAL DIRECTOR <u>Wm. J. Johnson &amp; Sons</u>						25a. REC'D BY REGISTRAR <u>B. L. M.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
DATE <u>FEB 7 1966</u>											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

01913

01861

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>RURAL - RANDALLSTOWN</b> c. LENGTH OF STAY IN 1b <b>15 Years</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Box 129 - Old Court Rd - Randallstown</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTO.</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>RURAL RANDALLSTOWN</b> d. STREET ADDRESS <b>Old Court Rd - Randallstown</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>Aquila BENSON GROVE</b>			4. DATE OF DEATH Month Day Year <b>2 17 1966</b>		
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/13/76</b>	9. AGE (In years last birthday) <b>90 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Central Govt - Long Term Housing</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Insurance</b>		11. BIRTHPLACE (County & State, or foreign country) <b>YORK COUNTY PENNA.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>Tyding GROVE</b>		
14. MOTHER'S MAIDEN NAME <b>-</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		
16. SOCIAL SECURITY NO. <b>216-46-5205</b>			17. INFORMANT <b>WIFE - MRS. HELEN GROVE</b> Address <b>Old Court Rd RANDALLSTOWN</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>UREMIA</b> 744X OUE TO <b>HYPERTENSION</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, OUE TO (b) (c)					INTERVAL BETWEEN ONSET AND DEATH <b>1 WEEK</b> <b>10 YEARS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <del>(this hospital)</del> attended the deceased from <b>DEC. 12, 1952</b> to <b>FEB. 17, 1966</b> , that (I) (we) last saw the deceased alive on <b>FEB. 15, 1966</b> , and that death occurred at <b>6:15 A.M.</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>Edwin L. Pierpont</b>			22b. DATE SIGNED <b>2/17/66</b>		
22c. PHYSICIAN'S NAME (Type) <b>EDWIN L. PIERPONT, M.D.</b>			22d. ADDRESS <b>8204 LIBERTY RD - BALTO., MD. 21207</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/18/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>	
23d. LOCATION (City, town or county) <b>Balto</b>		23e. (State) <b>MD</b>		23f. (Zip) <b>21207</b>	
24. FUNERAL DIRECTOR <b>Boring Myers 8728 Liberty Rd Randallstown</b>			25a. REC'D BY REGISTRAR <b>FEB 21 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>

MEDICAL CERTIFICATION



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove to open papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01862

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>232 Glenmore Ave</b>		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>Balto</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> d. STREET ADDRESS <b>232 Glenmore Ave</b>	
3. NAME OF DECEASED (Type or print) First <b>Lettie M.</b> Middle <b>Grove</b>		4. DATE DEATH <b>Feb. 4/66</b> 19 <b>66</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 10/72</b> 93 yrs.
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		9b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
10a. BIRTHPLACE (County & State, or foreign country) <b>Penna.</b>		10b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. FATHER'S NAME <b>Hubley</b>		12. MOTHER'S MAIDEN NAME <b>Unknown</b>	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>None</b>		14. SOCIAL SECURITY NO. <b>Mr. Volz 232 Glenmore Ave</b>	
15. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO <b>1201</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>Arteriosclerotic C. V. D.</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1955</b> to <b>2/4</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>2/27</b> , 19 <b>66</b> , and that death occurred at <b>5:12</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>J. C. Pours</b>		22b. DATE SIGNED <b>2/5/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>J. C. Pours</b>		22d. ADDRESS <b>7225 Frederick Ave</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>Feb. 7/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>		23d. LOCATION (City, town or county) (State) <b>Balto, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke F.D. 4101 Edmondson Ave</b>		25a. REC'D BY REGISTRAR <b>DATE 7 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>William Judge</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

01913

01863

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7714 Queen Anne Drive</u>		d. STREET ADDRESS <u>7714 Queen Anne Drive</u>	
3. NAME OF DECEASED (Type or print) <u>Charles M. Groves</u>		4. DATE OF DEATH <u>February 5th, 1966</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 12, 1907</u>
9. AGE (In years last birthday) <u>58</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supply</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bendix Corp.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Charles F. Groves</u>		14. MOTHER'S MAIDEN NAME <u>Mary R. Lynch</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>216-09-7866</u>	
17. INFORMANT <u>Mrs. Edna F. Groves</u>		Address <u>(Same)</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>2000 RETICULUM CELL SARCOMA</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>22 MOS</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CHRONIC BRONCHITIS</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>AUG 24, 1962</u> to <u>FEB 5, 1966</u> , that (I) (we) last saw the deceased alive on <u>FEB 5, 1966</u> , and that death occurred at <u>8 A</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Leonard Paul Berger MD</u>		22b. DATE SIGNED <u>2/5/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>LEONARD PAUL BERGER MD</u>		22d. ADDRESS <u>8100 HARFORD RD</u>	
23a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2/8/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem. Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Balto. Md.</u>
24. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc 5305 Harford Road.</u>		25a. REC'D BY REGISTRAR <u>FEB 8 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

01916		01864	
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mount Wilson</b> c. LENGTH OF STAY IN 1b <b>21 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Mount Wilson State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>South Cumberland</b> d. STREET ADDRESS <b>130 Arch St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Charles Henry GROWDEN</b>		4. DATE OF DEATH Month <b>2</b> Day <b>16</b> Year <b>1966</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-23-96</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Construction worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Textile</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania Bedford Valley</b>
13. FATHER'S NAME <b>William Growden</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>214-07-1953</b>	
17. INFORMANT <b>Hosp. records, Mt. Wilson St. Hospital</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Tuberculosis</b> 0021 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 mo.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Multiple Cerebral Infarcts, Arteriosclerotic Cardio-Vascular disease.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1-26-1966</b> , to <b>2-16-1966</b> , that (I) (we) last saw the deceased alive on <b>2-16-1966</b> , and that death occurred at <b>5:52 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Wm. Newcomer</b>		22b. DATE SIGNED <b>2-17-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Wm. Newcomer, M.D., Superintendent</b>		22d. ADDRESS <b>Mount Wilson, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Feb. 20, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>	23d. LOCATION (City, town or county) (State) <b>Cumberland, Md.</b>
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>		25a. REC'D BY REGISTRAR <b>FEB 21 1966</b>	25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please enclose carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01917

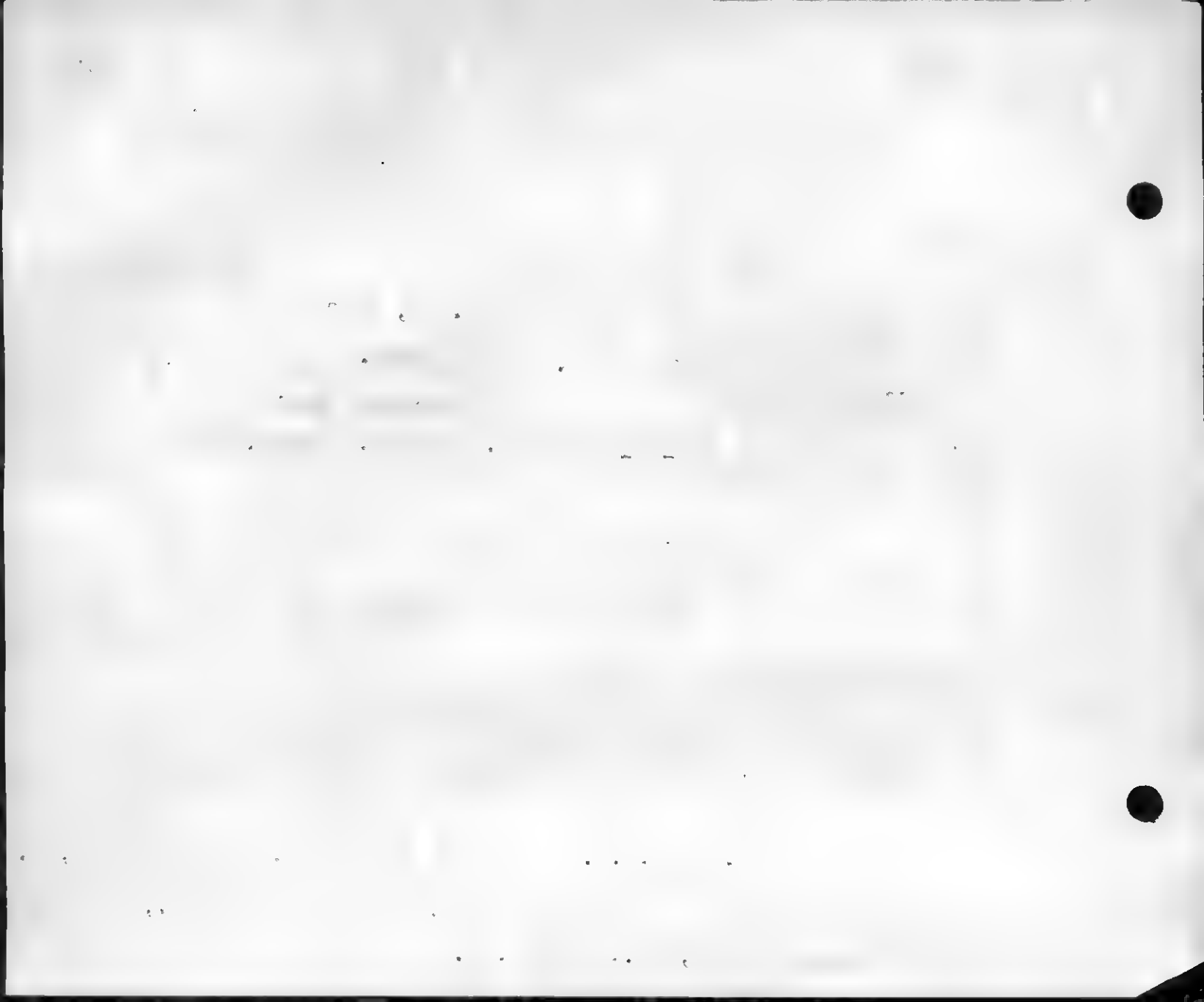
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

0-565

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b> c. LENGTH OF STAY IN b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>2 Eastship Road</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Dundalk 21222</b> d. STREET ADDRESS <b>2 Eastship Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>PAUL (NMN) GUNTER</b>		4. DATE OF DEATH <b>February 23rd 19 66</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 28, 1913</b>
9. AGE (in years last birthday) <b>52 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Methods Coordinator Steel Mfrgr.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Gunter</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Davis</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-09-1809</b>	
17. INFORMANT <b>Mrs. Doris F. Gunter, same as #2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute coronary thrombosis</b> DUE TO (b) <b>arteriosclerotic heart disease</b> DUE TO (c) <b>7 years</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 1954</b> to <b>9-25, 1966</b> that (I) (we) last saw the deceased alive on <b>2-19 1966</b> and that death occurred at <b>M</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Wyman K. Wong, M.D.</b>		22b. DATE SIGNED <b>2/24/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Wyman K. Wong, M.D.</b>		22d. ADDRESS <b>6901 Dunmanway, Dundalk 21222, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/25/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore Co., Maryland</b>	
24. FUNERAL DIRECTOR <b>Walter Brooks Bradley, Inc., Dundalk, Md.</b>		25a. REC'D BY REGISTRAR <b>FEB 23 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Judge</b>			



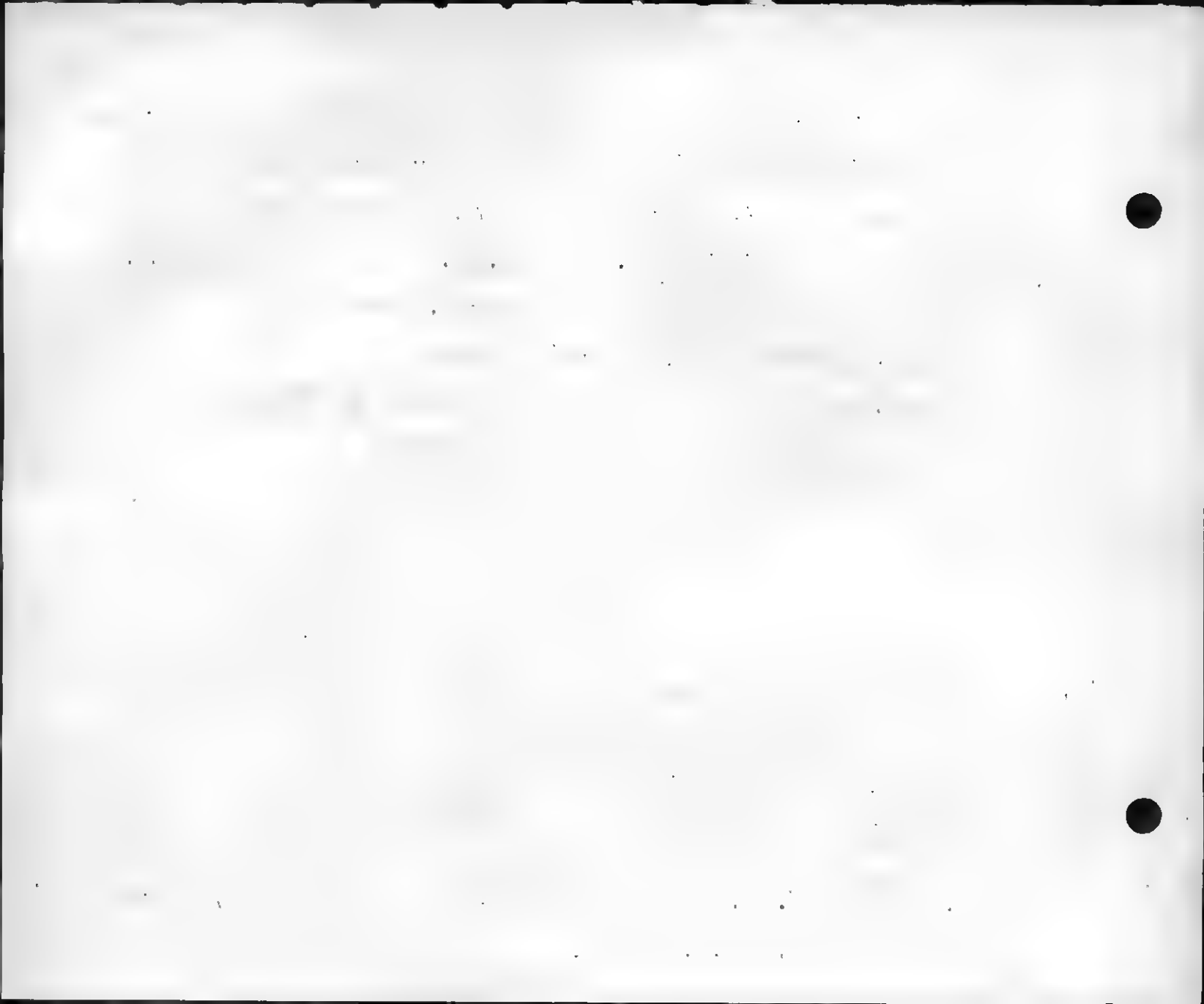
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 74 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
01918  
CERTIFICATE OF DEATH  
01866

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Providence (Towson 4)</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Providence (Towson 4)</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Providence Methodist Church</u>				d. STREET ADDRESS <u>1310 Providence Road</u>			
3. NAME OF DECEASED (Type or print) First <u>William E.</u> Middle <u>Guy</u> Last <u>Dr.</u>				4. DATE OF DEATH Month <u>February</u> Day <u>21</u> Year <u>1966</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 19, 1888</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter-retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self employed</u>		9. AGE (In years last birthday) <u>77</u> yrs.		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James E. Guy</u>				14. MOTHER'S MAIDEN NAME <u>Laura E. CARTER</u>			
15. WAS DECEASED EVER IN U.S. ARMY OR FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>None</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Family records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>-</u>							INTERVAL BETWEEN ONSET AND DEATH <u>many hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Benign Prostatic Hypertrophy</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>-</u>		20c. TIME OF INJURY Month, Day, Year Hour <u>3</u> a.m. <u>p.m.</u> <u>Feb 21 1966</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-</u>		20f. (City or town) <u>-</u>		(County) <u>-</u>		(State) <u>-</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept</u> , 19 <u>64</u> , to <u>Feb</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>1/24</u> , 19 <u>66</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Robert T. Levy M.D.</u>				22b. DATE SIGNED <u>2/23/66</u>		22c. PHYSICIAN'S NAME (Type) <u>Robert T. Levy M.D.</u>	
22d. ADDRESS <u>114 Macmillan Arts Bldg</u>				22e. REC'D BY REGISTRAR <u>MAR 2 1966</u>			
22f. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			
23b. DATE THEREOF <u>Feb. 24, 1966</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Providence Cemetery</u>			
23d. LOCATION (City, town or county) <u>Providence, Maryland</u>				(State) <u>Maryland</u>			
24. FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Maryland</u>				25a. ADDRESS <u>-</u>			



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

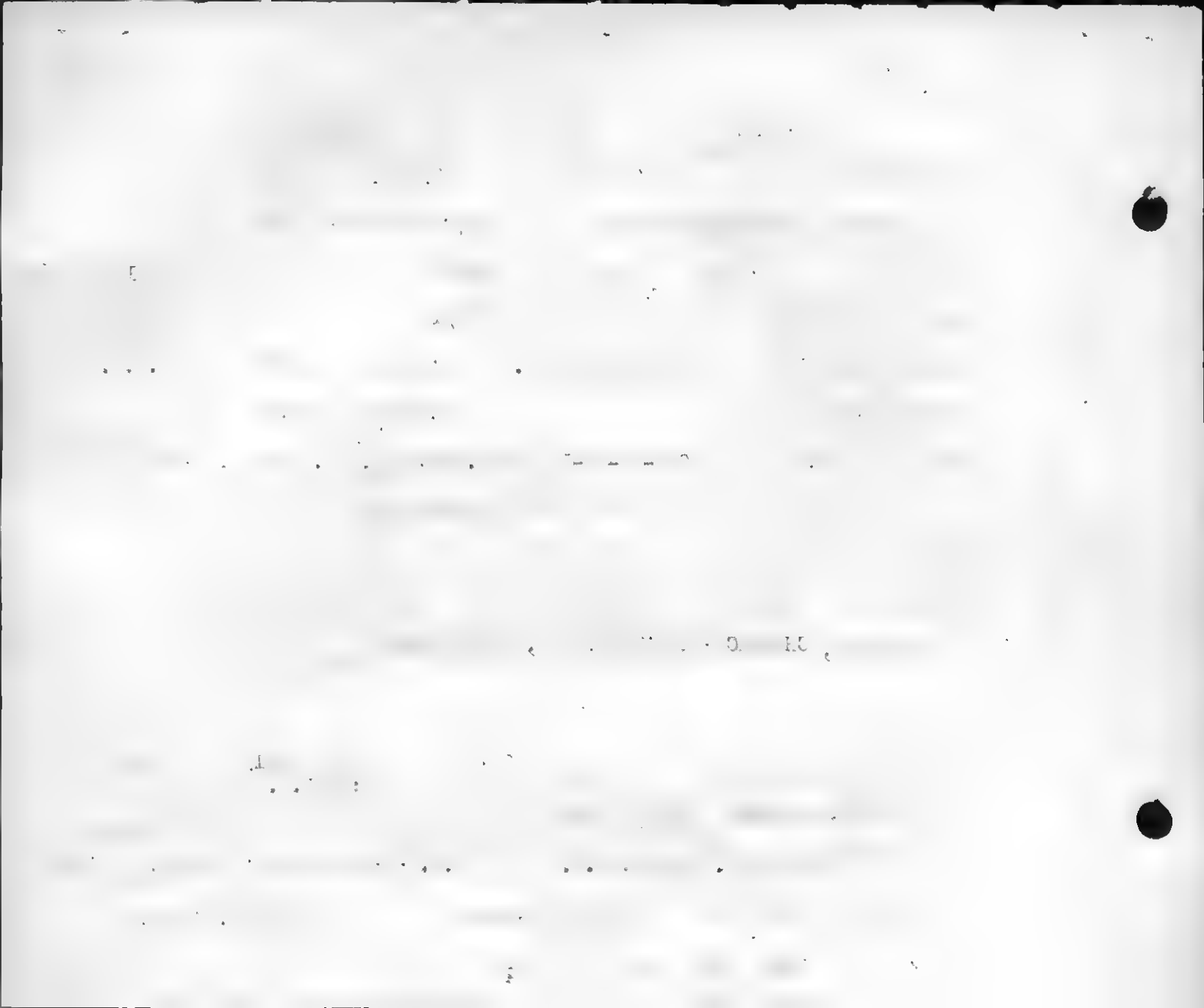
01919

01867

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		d. STREET ADDRESS <b>4726 SHAMROCK AVENUE</b>	
3. NAME OF DECEASED (Type or print) First <b>RAYMOND</b> Middle <b>JOHN</b> Last <b>HAGER</b>		4. DATE OF DEATH Month <b>2</b> Day <b>19</b> Year <b>19 66</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/8/10</b>
9. AGE (In years last birthday) <b>55</b>		IF UNDER 1 YEAR: Months <b>55</b> Days <b>19</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TOW MOTOR OPERATOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CAN DIVISION CO.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>GEORGE HAGER</b>		14. MOTHER'S MAIDEN NAME <b>ELIZABETH (UNKNOWN) OCHSE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>218-03-01-14</b>	
17. INFORMANT <b>VETERANS</b>		Address <b>HOSPITAL</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PNEUMONIA, RIGHT LOWER LOBE</b> <b>140X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DUE TO</b> (c) <b>DUE TO</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 WEEK</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>HEPATITIS, CHRONIC PLYELONEPHRITIS, KIDNEY STONE</b>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2/18</b> , 19 <b>66</b> , to <b>2/19</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>2/19</b> , 19 <b>66</b> , and that death occurred at <b>4:50 P.M.</b> on the causes and on the date stated above.			
22a. SIGNATURE <i>Conrado L. Mancao</i>		22b. DATE SIGNED <b>2/19/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>CONRADO L. MANCAO, M.D.</b>		22d. ADDRESS <b>V.A. HOSPITAL, FORT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/23/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>GARDENS OF FAITH</b>		23d. LOCATION (City, town or county) (State) <b>BALTIMORE, MARYLAND</b>	
24. FUNERAL DIRECTOR <b>SCHIMUNEK, FUNERAL HOME, BALTIMORE, MARYLAND</b>		25a. REC'D BY REGISTRAR <b>FILED 20 1966</b>	
		25b. REGISTRAR'S SIGNATURE <i>James J. Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

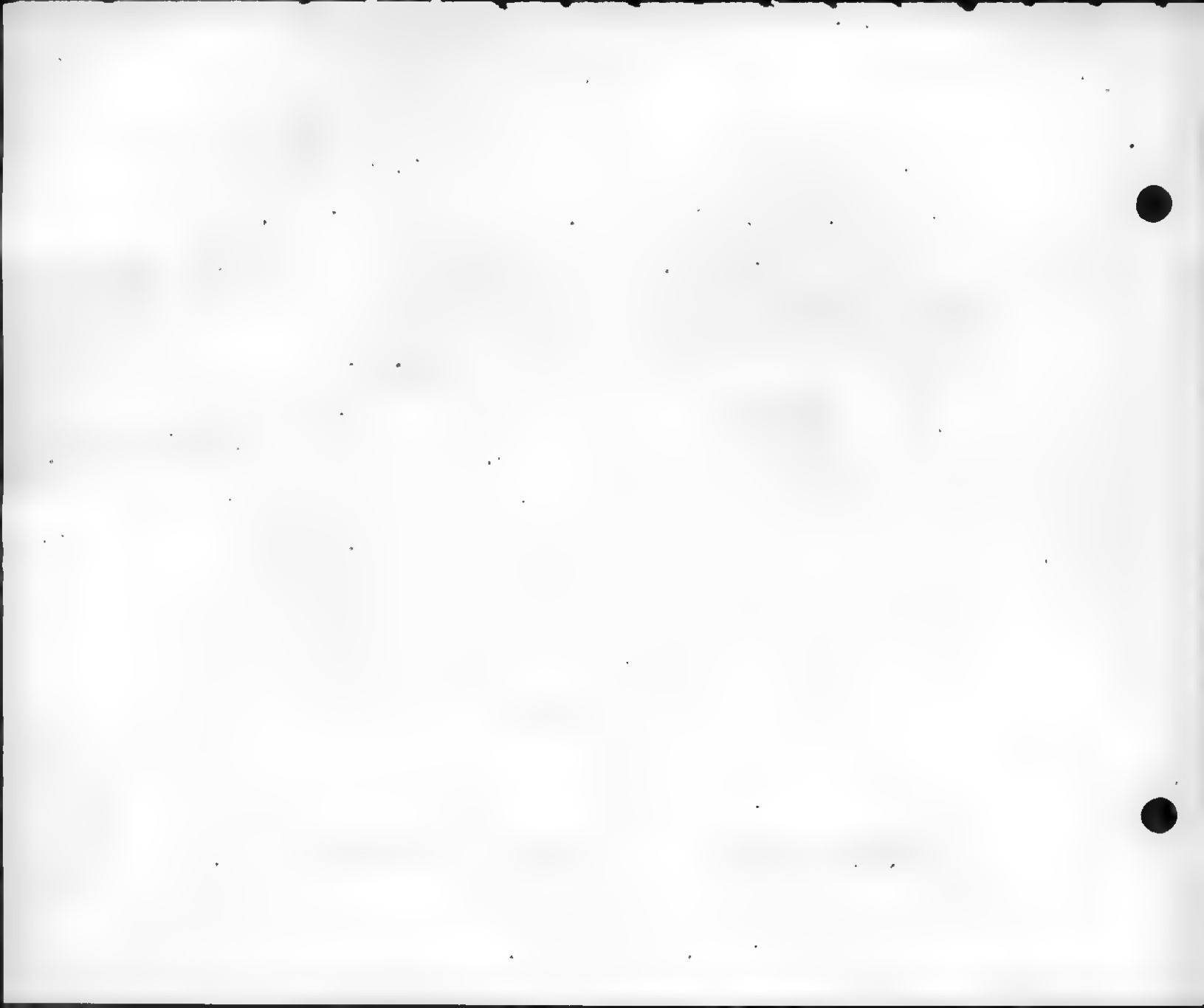
M

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

01868

01920

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pikesville</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Professional House, 133 Slade Ave.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>Arlington Park Apts.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MERLE</b> Middle <b>F.</b> Last <b>HAMBURGER</b>		4. DATE OF DEATH <b>February 23, 1966</b> Month <b>February</b> Day <b>23</b> Year <b>19</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Phila., Pa.</b>
13. FATHER'S NAME <b>Noses Friedenwald</b>		14. MOTHER'S MAIDEN NAME <b>Jane Ahlborn</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>220-44-4540</b>	
17. INFORMANT <b>Mrs. Isaac Hamburger- 101 Brightside Ave. Pikesville 8, Md</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute coronary occlusion</b> DUE TO (b) <b>myocardial infarction</b> DUE TO (c) <b>atherosclerotic heart disease</b> INTERVAL BETWEEN ONSET AND DEATH <b>6 hrs</b> <b>3 c yrs</b> <b>5 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this-hospital) attended the deceased from <b>April 4, 1963</b> to <b>Feb. 23, 1966</b> , that (I) (we) last saw the deceased alive on <b>Feb. 23, 1966</b> , and that death occurred at <b>7 p.m.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Jonas Cohen</b>		22b. DATE SIGNED <b>Feb 24, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. JONAS COHEN</b>		22d. ADDRESS <b>6702 Park Heights Ave.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>2/25/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Hebrew</b>	23d. LOCATION (City, town or county) (State) <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS INC. 6010 Reist Rd.</b>		25a. REC'D BY REGISTRAR <b>FEB 28 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
01921 CERTIFICATE OF DEATH 01869

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Summit Home, Catonsville, Md.</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>2562 W. Fairmount Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Emma</b>		First <b>Emma</b> Middle <b>C.</b> Last <b>Hamilton</b>		4. DATE OF DEATH Month <b>February</b> Day <b>2</b> Year <b>1966</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 5, 1880</b>	9. AGE (in years last birthday) <b>85 yrs.</b>	IF UNDER 1 YEAR Months <b>5</b> Days <b>7</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore</b>			
13. FATHER'S NAME <b>George Bowers</b>			14. MOTHER'S MAIDEN NAME <b>Mary E. Brown</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Herbert C. Bowers, 506 Saratoga Ave., N.E. Glen Burnie</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>① Acute &amp; chronic Congestive Heart Failure</b> DUE TO (b) <b>② Arterio Sclerotic Heart Disease</b> DUE TO (c) <b>③ Residuals of old stroke</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs. 5 mos.</b>		
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>1/13/66</b> to <b>2/2/66</b> , that (I) (we) last saw the deceased alive on <b>2/2/66</b> , and that death occurred at <b>11:00 P.M.</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>W E Mc Grath</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2/4/66</b>			
22c. PHYSICIAN'S NAME (Type) <b>W E Mc Grath</b>		22d. ADDRESS <b>1303 Frederick Rd (212 ss)</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 5, 66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Western Cemetary</b>			
23d. LOCATION (City, town or county) (State) <b>Baltimore, Maryland</b>		24. FUNERAL DIRECTOR <b>G. Truman Schwab, 3512 Frederick Ave., Baltimore, Maryland, 21229</b>					
25a. REC'D BY REGISTRAR <b>FEB 7 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Md.</b>		b. COUNTY <b>Balto.</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>5719 McCormick Ave.</b>						d. STREET ADDRESS <b>5719 McCormick Ave.</b>					
3. NAME OF DECEASED (Type or print) <b>EMMA HILDA HARDESTY</b>		4. DATE OF DEATH <b>February 3 19 66</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		8. DATE OF BIRTH <b>27 December 1878</b>	
9. AGE (In years last birthday) <b>87 yrs.</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>at home</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13. FATHER'S NAME <b>Thomas Pyle</b>	
14. MOTHER'S MAIDEN NAME <b>Lydia Scarborough</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Wm. P. Hardesty, 5719 McCormick Ave. 21206</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> <b>4200</b> DUE TO (b) <b>Congestive Heart Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Arteriosclerotic Heart Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b> <b>4 weeks</b> <b>?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Anemia</b>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1957</b> to <b>2/3</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>2/3</b> , 19 <b>66</b> , and that death occurred at <b>12:05 P.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Paul G. Mueller</b>		22b. DATE SIGNED <b>2/3/66</b>		22c. PHYSICIAN'S NAME (Type) <b>Paul G. Mueller</b>		22d. ADDRESS <b>6411 Belair Rd Baltimore Md.</b>		22e. ATTENDING PHYS. <input checked="" type="checkbox"/>		22f. MED. DIRECTOR <input type="checkbox"/>	
22g. STAFF PHYS. <input type="checkbox"/>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>7 Feb 66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>		23d. LOCATION (City, town or county) <b>Baltimore, Md.</b>		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Ulrich Funeral Home, Baltimore, Md.</b>		25a. REC'D BY REGISTRAR <b>FEB 10 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>							



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

# MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01571

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>DUNDALK</b> c. LENGTH OF STAY IN 1b <b>22 years</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>321 PINE STREET</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>DUNDALK</b> d. STREET ADDRESS <b>321 PINE STREET</b>	
3. NAME OF DECEASED (Type or print) <b>MACY THOMAS HARRIS</b>		4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>28</b> Year <b>19 66</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 25, 1925</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BETHLEHAM STEEL</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>STEEL</b>	
11. BIRTHPLACE (State or foreign country) <b>VAUGHAN, NORTH CAROLINA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>RUDOLPH HARRIS</b>		14. MOTHER'S MAIDEN NAME <b>LUCY WILLIAMS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>243-30-1474</b>	
17. INFORMANT <b>MRS. GRACE HARRIS</b>		Address <b>321 PINE STREET</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Rheumatic Carditis Mitral</b> DUE TO (b) <b>insufficiency &amp; stenosis</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>M B Davis</b>		M.D. _____	
EXAMINER'S NAME (Type) <b>M B Davis MD-6800 McK...</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>3 -7-66</b>	22c. NAME OF CEMETERY OR CREMATORY <b>ARBUTUS MEMORIAL PARK ARBUTUS,</b>	22d. LOCATION (City, town, or country) (State) <b>MARYLAND</b>
23. FUNERAL DIRECTOR <b>THE MORTON &amp; DYETT</b>		ADDRESS <b>1701 LAURENS STREET</b>	
24a. REC'D BY REGISTRAR <b>DATE MAR 3 1966</b>		24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

MEDICAL CERTIFICATION

3/1/66  
DATE SIGNED

18487

112



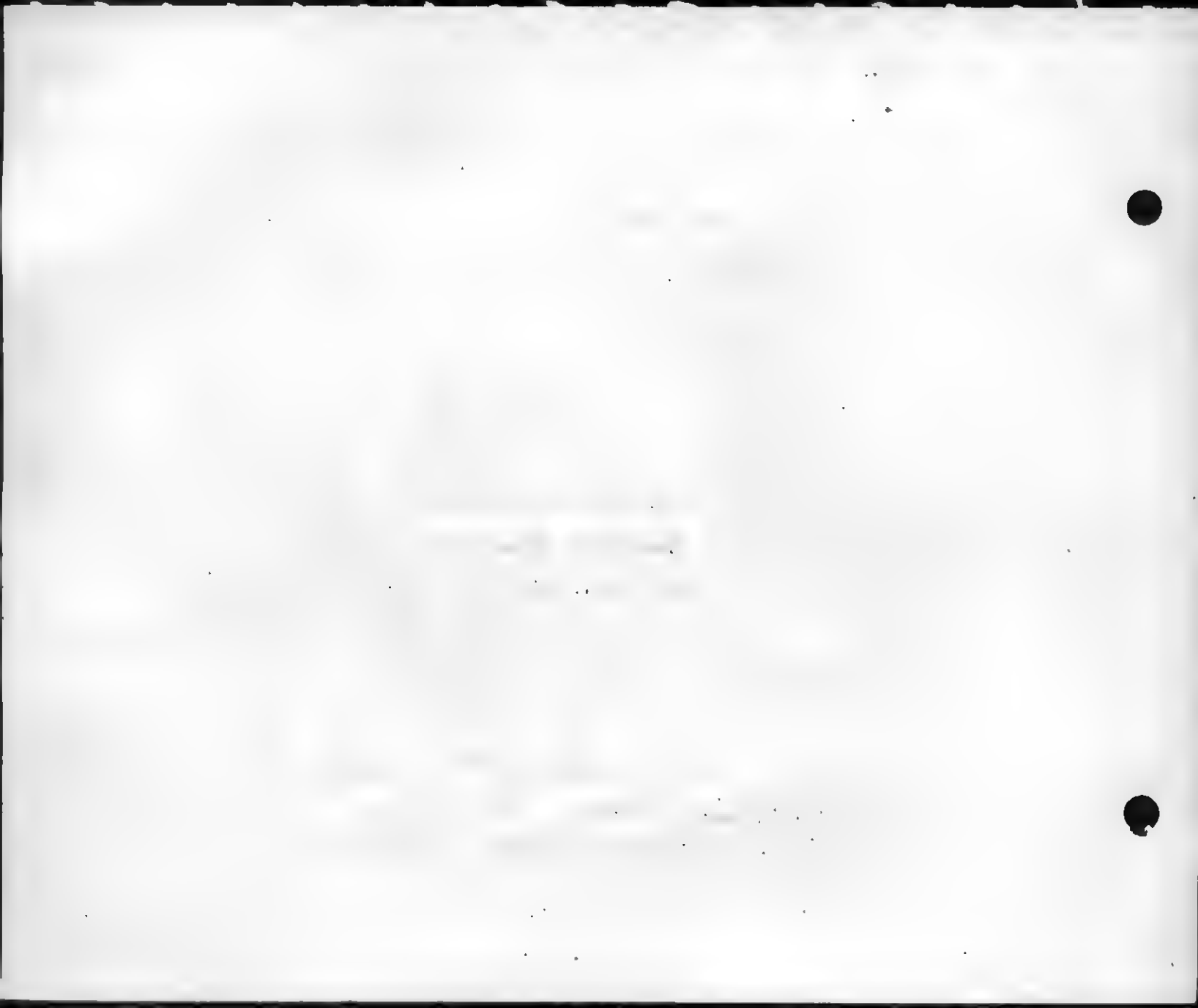
1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Balt. Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balt.</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore Catonsville</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Essex</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>CATON RIDGE NURSING HOME</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>HARTZ EMMA E.</u>	4. DATE OF DEATH <u>2 - 19 1966</u>	5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>7/7/78</u>	9. AGE (in years last birthday) <u>87</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (County & State, or foreign country) <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lewis Kessler</u>		14. MOTHER'S MAIDEN NAME <u>Elinor Matters</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Daughter (same as above)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA</u> 154A DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>SEVERE ANEMIA</u> DUE TO (c) <u>INOPERABLE C.A. OF RECTUM</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Sept. 15, 1965</u> to <u>2-19, 1966</u> , that (I) (we) last saw the deceased alive on <u>2-19-1966</u> , and that death occurred at <u>1 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Cesar Valle Caverio</u> M.D.		22b. DATE SIGNED <u>2-19-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>CESAR VALLE CAVERIO</u>		22d. ADDRESS <u>2624 LIBERTY RD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2/23/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>	23d. LOCATION (City, town or county) (State) <u>Balt. Co. Md.</u>
24. FUNERAL DIRECTOR <u>John J. Connelly</u>		25a. REC'D BY REGISTRAR <u>21</u>	
25b. REGISTRAR'S SIGNATURE <u>John Charles Judge</u>		DATE <u>FEB 23 1966</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the burial-transit permit from this certificate. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00

VA 115 (4)  
MAY 1966

MD  
M  
2  
1  
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01925

CERTIFICATE OF DEATH

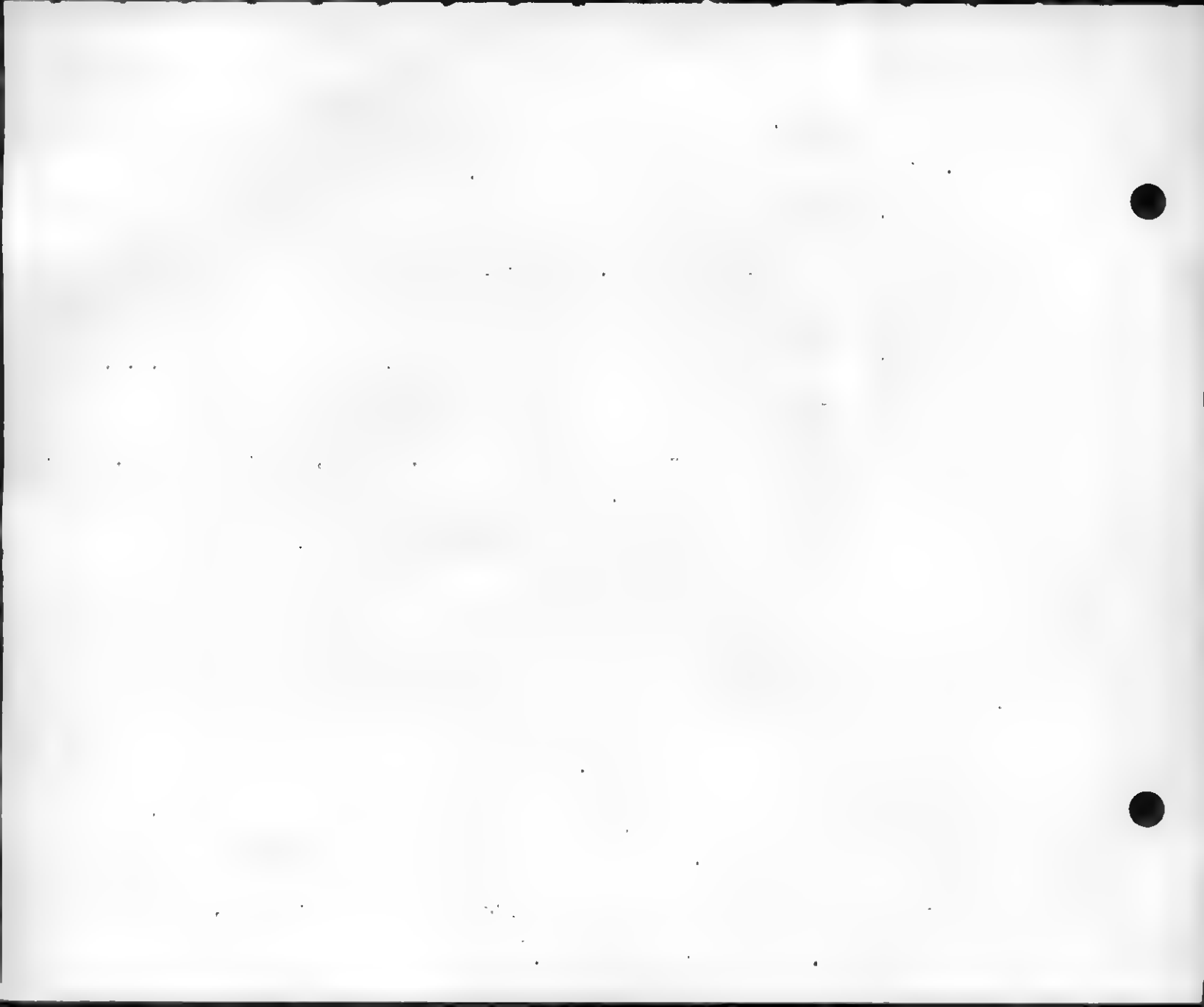
01873

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Timonium</u>		c. LENGTH OF STAY IN TB <u>6 years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>NONE</u>		d. STREET ADDRESS <u>3 Northwood Dr -</u>	
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>May</u> Last <u>Hedrick</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>26</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 18/1881</u>
9. AGE (In years last birthday) <u>84</u> yrs		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Craumer</u>		14. MOTHER'S MAIDEN NAME <u>Alice</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>216-10-7022A</u>	
17. INFORMANT <u>Alice Kraut</u>		Address <u>Timonium, Md.</u> <u>3 Northwood Dr</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>7824</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>old age (84)</u> (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>  </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER) <u>NO</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>2-26</u> , 19 <u>66</u> , to <u>  </u> , 19 <u>  </u> , that (I) (we) last saw the deceased alive on <u>Nov 18</u> , 19 <u>  </u> , and that death occurred at <u>3:42 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>James R. Leonard MD</u>		22b. DATE SIGNED <u>2-26-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>James R. Leonard</u>		22d. ADDRESS <u>2045 York Rd. Timonium, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>March 1, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Poplar Grove Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore Co., Maryland</u>	
24. FUNERAL DIRECTOR <u>Wm. Cook-Brooks Towson, 1050 York Road, Towson 4, Maryland</u>		25a. REC'D BY REGISTRAR <u>ONE R 3 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>LANSDOWNE</b> c. LENGTH OF STAY IN 1b <b>LANSDOWNE</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>167 STAFFORD STREET 21227</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>LANSDOWNE</b> d. STREET ADDRESS <b>167 STAFFORD STREET 21227</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>ANNA</b> Middle <b>M.</b> Last <b>HEINZERLING</b>			4. DATE OF DEATH Month <b>2</b> Day <b>20</b> Year <b>19 66</b>						
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/8/1879</b>		9. AGE (In years last birthday) <b>86</b> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>UNKNOWN</b>					14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>				
15. WAS DECEASED EVER IN U.S. ARMY OR FORCES? (Yes, no, or unknown) <b>NO</b>			16. SOCIAL SECURITY NO. <b>-----</b>		17. INFORMANT <b>MARGARET M. THIELE, 167 STAFFORD ST. 21227</b> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO (b) <b>Cerebral Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>2 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>June 18, 1969</b> , to <b>2-19, 1966</b> , that (I) (we) last saw the deceased alive on <b>2-19, 1966</b> , and that death occurred at <b>5 P.M.</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>John P. Urlock Jr</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2/21/66</b>		
22c. PHYSICIAN'S NAME (Type) <b>JOHN P. URLOCK, JR</b>					22d. ADDRESS <b>1227 WASHINGTON BOULEVARD</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE THEREOF <b>2/22/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>WESTERN CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>BALTIMORE, MARYLAND</b>		
24. FUNERAL DIRECTOR <b>HUBBARD FUNERAL HOME, 4107 WILKENS AVE. 21229</b>					25a. REC'D BY REGISTRAR <b>FILED 2-20-66</b>		25b. REGISTRAR'S SIGNATURE <b>James H. Judge</b>		



1  
FOR STATE  
HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01927

01975

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore-rural</b>		c. LENGTH OF STAY IN 1b <b>Baltimore-rural</b>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore-rural</b>		d. STREET ADDRESS <b>Dogwood Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Edward William Henry</b>		4. DATE OF DEATH Month <b>2</b> Day <b>1</b> Year <b>1966</b>		5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Mar 12 1912</b>		9. AGE (In years last birthday) <b>52</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>saint sprayer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bethlehem Steel</b>		11. BIRTHPLACE (State or foreign country) <b>Linneton Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>John Henry</b>		14. MOTHER'S MAIDEN NAME <b>M. Edith Hickey</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) <b>no</b>	
16. SOCIAL SECURITY NO. <b>705-12-2617</b>		17. INFORMANT <b>Mary E. Henry, McDonald Rd.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia, complicating gunshot wound of head</b> <b>981X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>shot in head</b> (c), stating the underlying cause last. DUE TO		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>shot in head</b>		20c. TIME OF INJURY Month, Day, Year <b>12 19 1965</b> Hour a.m. <b>12:30</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>home</b>		20f. (City or town) <b>Balto.-rural</b>		(County) <b>Balto.</b>		(State) <b>Md.</b>		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
21. ACTUAL SIGNATURE <b>Werner U. Spitz</b>		21. M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		21. DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>2/1/66</b>		22a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb 4 1966</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cem</b>	
22d. LOCATION (City, town, or country) <b>Balto Co.</b>		(State) <b>Md.</b>		23. FUNERAL DIRECTOR <b>Richard Byers</b>		ADDRESS <b>8728 Liberty Rd</b>		24a. REC'D BY REG STRAR <b>FEB 4 1966</b>		24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		24c. (City, town, or country) <b>Balto Co.</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

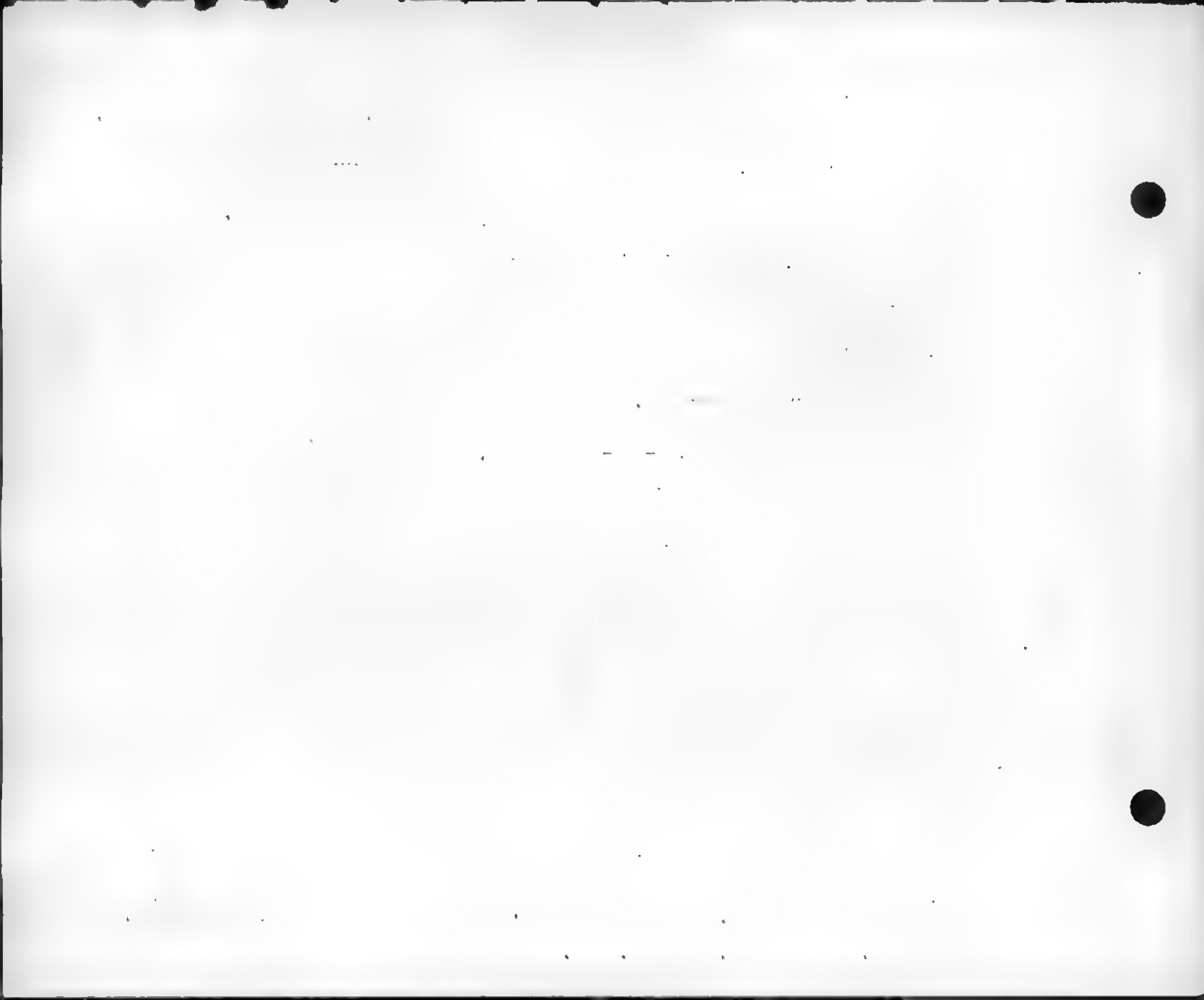
01923

01876

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) b. STATE <i>Md.</i> c. COUNTY <i>Balto.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Balto - Rural</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural-- Baltimore</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>8350 Ridgely Oak Rd</i>		d. STREET ADDRESS <i>8350 Ridgely Oak Rd.</i>	
3. NAME OF DECEASED (Type or print) <i>JOHN HANLEY HENSHAW</i>		4. DATE OF DEATH Month <i>Feb</i> Day <i>7</i> Year <i>1966</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>27 Nov 19</i>
9. AGE (In years last birthday) <i>46 yrs.</i>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Steamfitter</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John Henshaw Sr.</i>		14. MOTHER'S MAIDEN NAME <i>Rose Glock</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>220-09-8399</i>	
17. INFORMANT <i>Mrs. Marie Henshaw</i>		Address <i>(Same)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> DUE TO (b) <i>Diabetes</i> DUE TO (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO		INTERVAL BETWEEN ONSET AND DEATH <i>3 yrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John E. Hyle</i>		22. DATE SIGNED <i>2-4-66</i>	
EXAMINER'S NAME (Type) <i>JOHN E. HYLE</i>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>2/7/66</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Glen Haven Cemetery</i>	23d. LOCATION (City, town or county) (State) <i>Baltimore, Md.</i>
24. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc. Balto. Md. 21214</i>		25a. REC'D BY REGISTRAR <i>FEB 7 1966</i>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be completed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office, along with form PW3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



# FOR STATE- HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in 60 days after death.

VR A15ME (5)  
6M 1/66

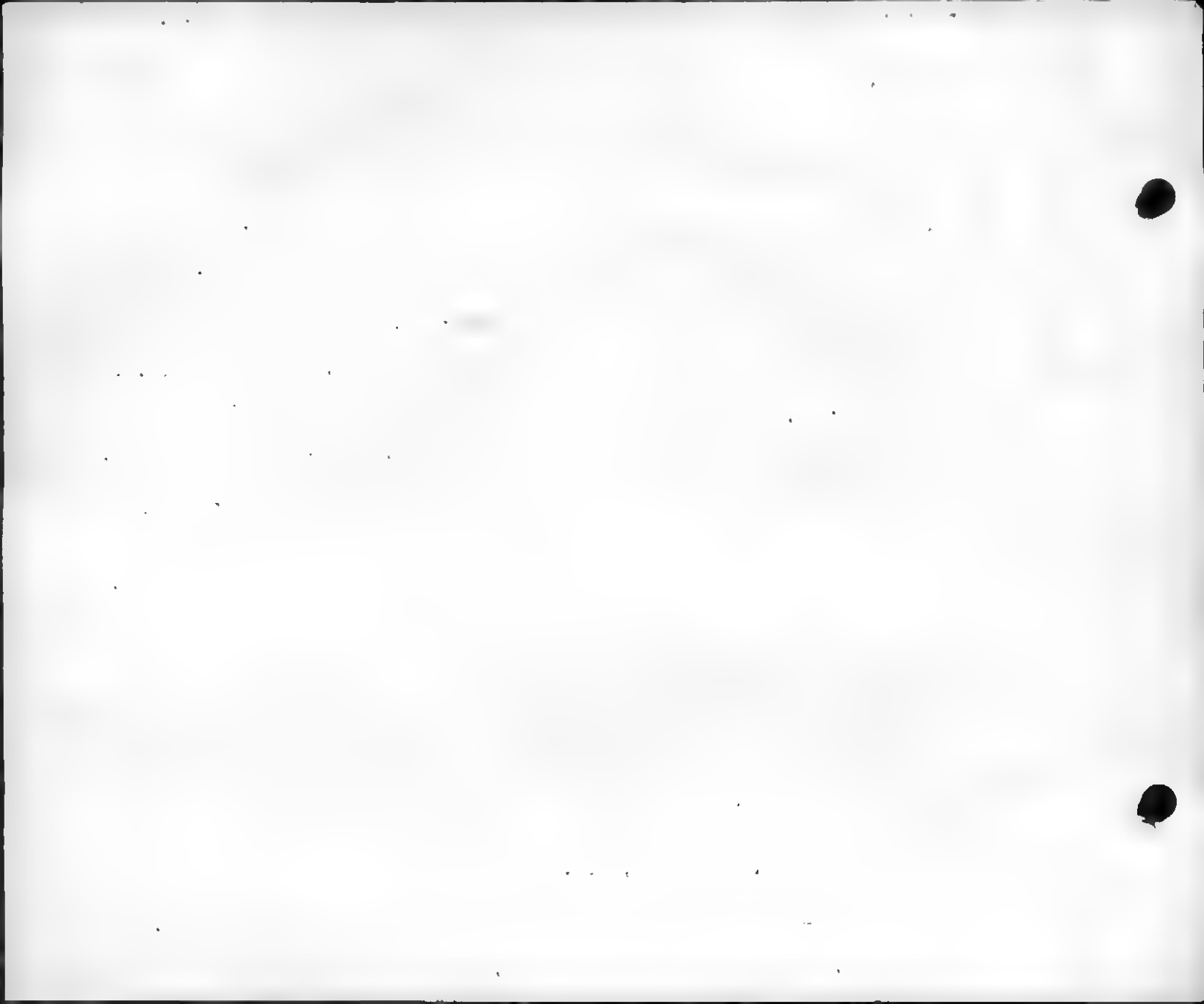
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01929

01877

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b>				b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore City</b>				c. LENGTH OF STAY IN TB <b>Towson</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore City 21234</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph's Hospital</b>				d. STREET ADDRESS <b>9807 Harford Rd.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Virginia Hitchcock</b>				4. DATE OF DEATH Month <b>Feb.</b> Day <b>6</b> Year <b>1966</b>							
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>MAY 9, 1920</b>		9. AGE (In years last birthday) <b>45 1/2</b>		10. UNDER 1 YEAR Months <b>9</b> Days <b>27</b> Hours <b></b> Min <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>				10b. KIND OF BUSINESS OR INDUSTRY <b></b>				11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>Walter R. Gilbert</b>				14. MOTHER'S MAIDEN NAME <b>Blanche Kirkpatrick</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOC. SEC. NO. <b>214031789</b>				17. INFORMANT Address <b>Donald J. Smith- 9807 Harford Rd. 21234</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> 442X DUE TO <b>Hypertensive Cardiac-Renal Syst</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b></b> DUE TO (c) <b>Vascular Disease</b>								INTERVAL BETWEEN ONSET AND DEATH <b>1 Hr</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b></b>				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b></b>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b></b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc) <b></b>		20f. (City or town) (County) (State) <b></b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22. DATE SIGNED <b>2/6/66</b>			
EXAMINER'S NAME (Type) <b>Charles F. O'Donnell, M.D.</b>				Address (Street, city, town, or county) <b></b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>				23b. DATE THEREOF <b>2-10-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>			
24. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc Baltimore, Md.</b>				25a. READ BY REG. STRAR DATE <b>FEB 8 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					



1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01878

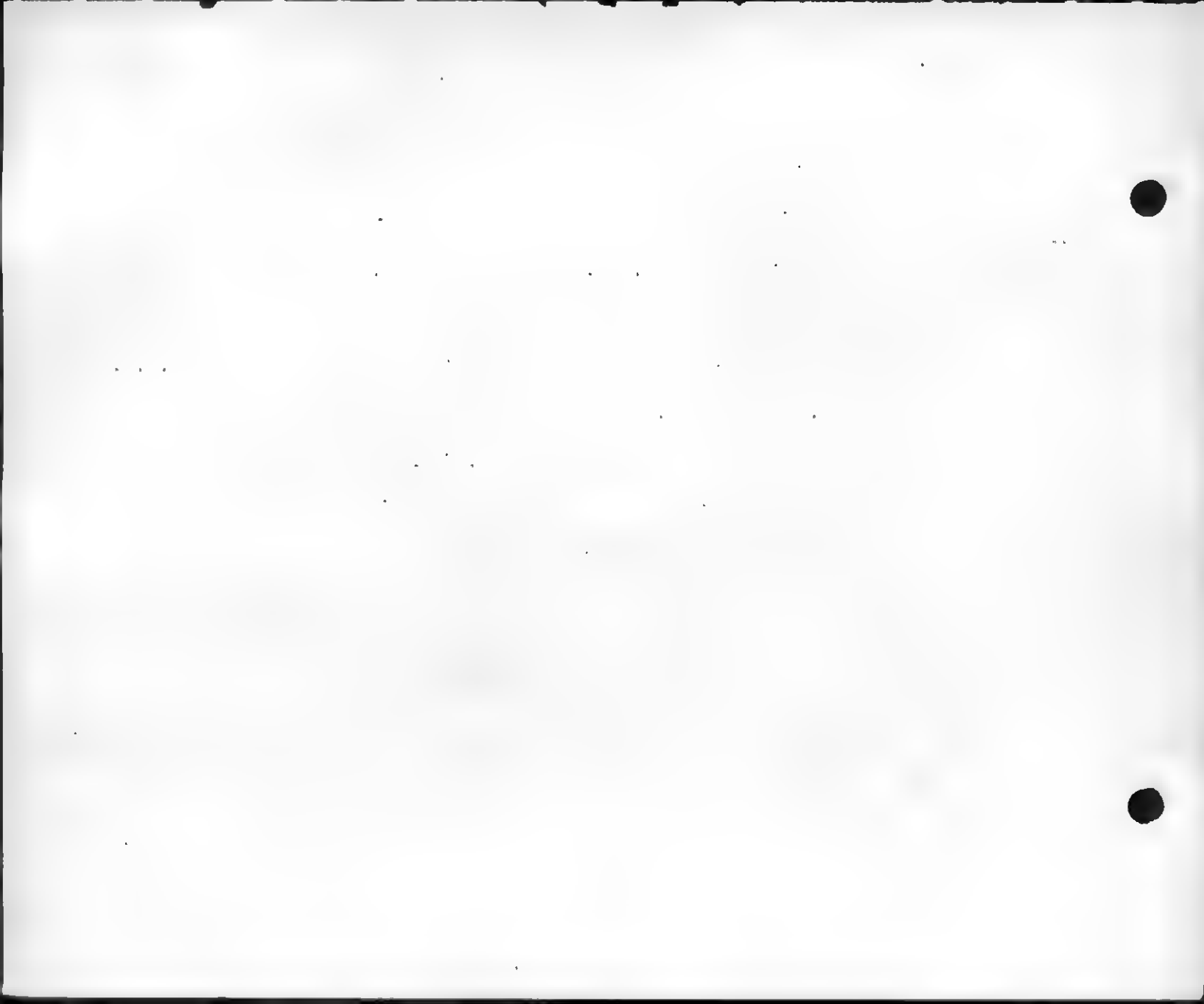
1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) b. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 15 Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		d. STREET ADDRESS 2228 Eutaw Place	
3. NAME OF DECEASED (Type or print) First FRED Middle E. E. Last HOFFMAN, JR.		4. DATE OF DEATH Month February Day 10 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/14/27
9. AGE (In years last birthday) 38 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MEAT CUTTER	
10b. KIND OF BUSINESS OR INDUSTRY ACME STORES		11. BIRTHPLACE (State or foreign country) NORTH CAROLINA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME FRED E. HOFFMAN, SR.	
14. MOTHER'S MAIDEN NAME GLENNIE LEWIS		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES W W II	
16. SOCIAL SECURITY NO. -----		17. INFORMANT Address CARL L. HOFFMAN - BROTHER	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Infection of Brain and Meninges DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) Shotgun Wound of Head. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Shot during altercation.	
20c. TIME OF INJURY Hour a.m. 8:15 Month, Day, Year 12/24 1965	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) House	20f. (City or town) (County) (State) Baltimore Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Petty		22. DATE SIGNED 2/10/66	
EXAMINER'S NAME (Type) Charles S. Petty, M.D.		Address (Street, city, town, or county)	

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 2/11/66	23c. NAME OF CEMETERY OR CREMATORY WEST LAWN CEMETERY	23d. LOCATION (City, town or county) (State) ELIZABETH CITY, NORTH CAROLINA
24. FUNERAL DIRECTOR HUBBARD FUNERAL HOME, 4107 WILKENS AVENUE, #29		25a. REC'D BY REGISTRAR DATE FEB 15 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

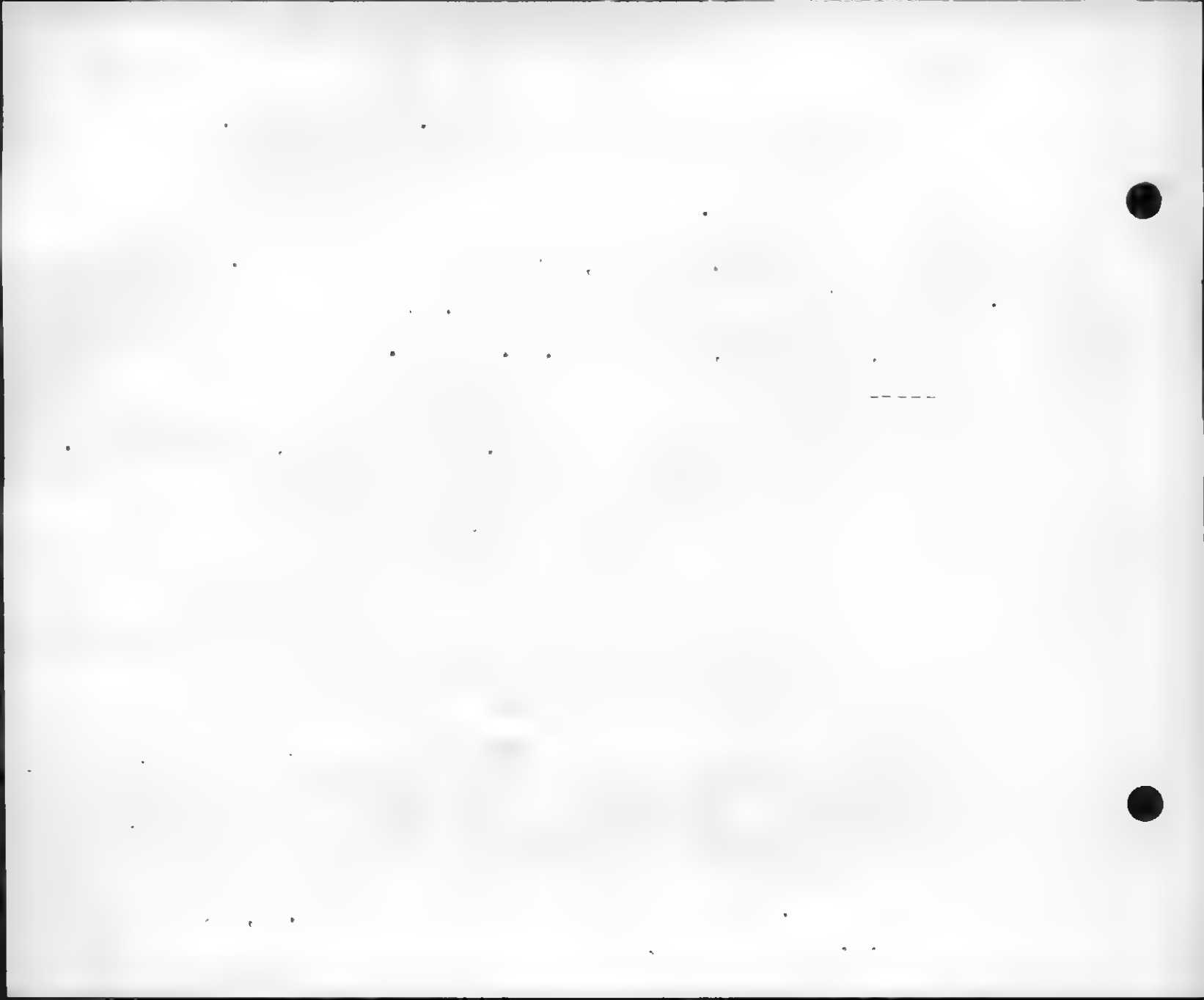
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute a certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01931					01879						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)						
a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM?		
Baltimore		Catonsville			Catonsville 28		3 Overbrook Rd.		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH		5. IS RESIDENCE ON A FARM?				
Howard E. Holland, Sr.					Feb. 5/66		19				
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)			
Male		white		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Feb. 7/94		71 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Retired, President					Holland Mfg. Co.		Conn.		USA		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME						
-----Holland					Unknown						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO.		17. INFORMANT				
(If yes give war or dates of service)					212 03 7975		Mrs. Mable Holland, 3 Overbrook Rd.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)											
DUE TO											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO											
DUE TO											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED?	
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year										20d. INJURY OCCURRED	
Hour a.m. 19										While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)										20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb. 20, 1965, to Feb. 5, 1966, that (I) (we) last saw the deceased alive on Feb. 4, 1966, and that death occurred at 7:00 AM, from the causes and on the date stated above.											
22a. SIGNATURE										22b. DATE SIGNED	
HARRY L. KNIPP, M.D.										2-7-66.	
22c. PHYSICIAN'S NAME (Type)										22d. ADDRESS	
HARRY L. KNIPP, M.D.										416 Edmondson Ave. Balt. 29 Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE THEREOF	
burial										Feb. 8/66	
23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City, town or county) (State)	
Woodlawn										Balto. 7, Md.	
24. FUNERAL DIRECTOR										25a. REC'D BY REGISTRAR	
Witzke F.D. 4101 Edmondson Ave										B 8 1966	
25b. REGISTRAR'S SIGNATURE											
James Judge											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01932

01880

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>5323 Clifton Ave.,</u>		d. STREET ADDRESS <u>5323 Clifton Ave.,</u>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Minnie</u> Middle <u>E.</u> Last <u>Holsinger</u>		<b>4. DATE OF DEATH</b> Month <u>Feb.</u> Day <u>7</u> Year <u>1966</u>	
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>W.</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>Aug. 28, 1876</u>	<b>9. AGE</b> (in years last birthday) <u>89</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS.: Hours <u>  </u> Min. <u>  </u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>--</u>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Va.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Jonathan Mason</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Sarah C. Ritchie</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give year or dates of service) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b> <u>  </u>	
<b>17. INFORMANT</b> <u>Orville A. Holsinger</u>		Address <u>5323 Clifton Ave.</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure and Uremia -</u> DUE TO <u>Generalized arteriosclerosis -</u> Conditions, if any, which gave rise to immediate cause (b) <u>  </u> (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>  </u>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>  </u> a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>		<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u> <b>20f. (City or town)</b> (County) (State) <u>  </u>	
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <u>1940</u> to <u>2-7-66</u> , 19 <u>  </u> , that (I) (we) last saw the deceased alive on <u>2-7-66</u> , 19 <u>  </u> , and that death occurred at <u>2:15</u> P.M. from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <u>Harry S. Gimbel</u>		<b>22b. DATE SIGNED</b> <u>2-8-66</u>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>HARRY S. GIMBEL</u>		<b>22d. ADDRESS</b> <u>4605 Edmondson Ave</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>2-10-1966</u>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Woodlawn</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Woodlawn, Md.</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>G. Howard Strong</u>		<b>25a. REC'D BY REGISTRAR</b> <u>Feb 11 1966</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>John Lewis Judge</u>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

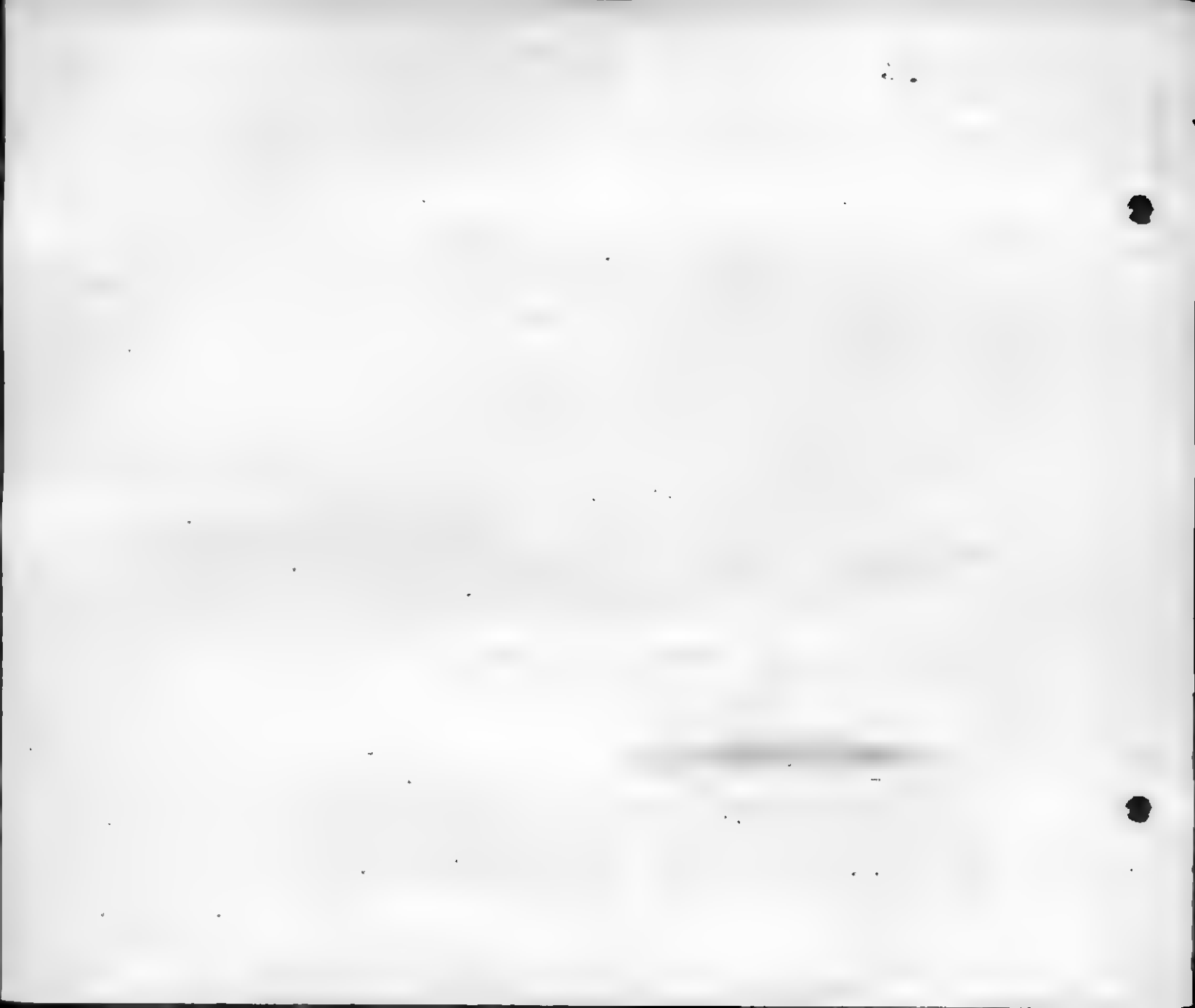
Reg. Dist. No.

01881

01933

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admision) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>	
c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1820 Forrest Road</b>		d. STREET ADDRESS <b>1820 Forrest Road</b>	
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>F.</b> Last <b>Horak</b>		4. DATE OF DEATH Month <b>2</b> Day <b>12</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-9-1946</b>
9. AGE (In years last birthday) <b>19</b> yrs.		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>12</b> Hours <b>19</b> Min <b>66</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Never Worked</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Fredrick Horak</b>		14. MOTHER'S MAIDEN NAME <b>Grace</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mr Fredrick Horak</b>		Address <b>1820 Forrest Road #34</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gastro-intestinal hemorrhage, cause undetermined</b> DUE TO <b>This boy developed meningitis when 9 months old.</b> (b) <b>His brain was so damaged that he never walked,</b> DUE TO <b>talked, and had no mentality whatsoever. At age 19,</b> (c) <b>he weighed about 30 lbs.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1946</b> , 19____, to <b>2-12-66</b> , 19____, that I last saw the deceased alive on <b>2-11-66</b> , 19____, and that death occurred at <b>2 A.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4508 Harford Road.</b> DATE SIGNED <b>2-12-66</b>			
ACTUAL SIGNATURE <b>C.W. Peake</b>		M.D. <b>4508 Harford Road.</b>	
PHYSICIAN'S NAME (Type) <b>C.W. Peake</b>		<b>Baltimore, Md. 21214</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2-14-1966</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore Co. Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>L. J. ...</b>		ADDRESS <b>2401 Belair Road</b>	
24a. REC'D BY REGISTRAR <b>FEB 15 1966</b>		24b. REGISTRAR'S SIGNATURE <b>J. J. ...</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



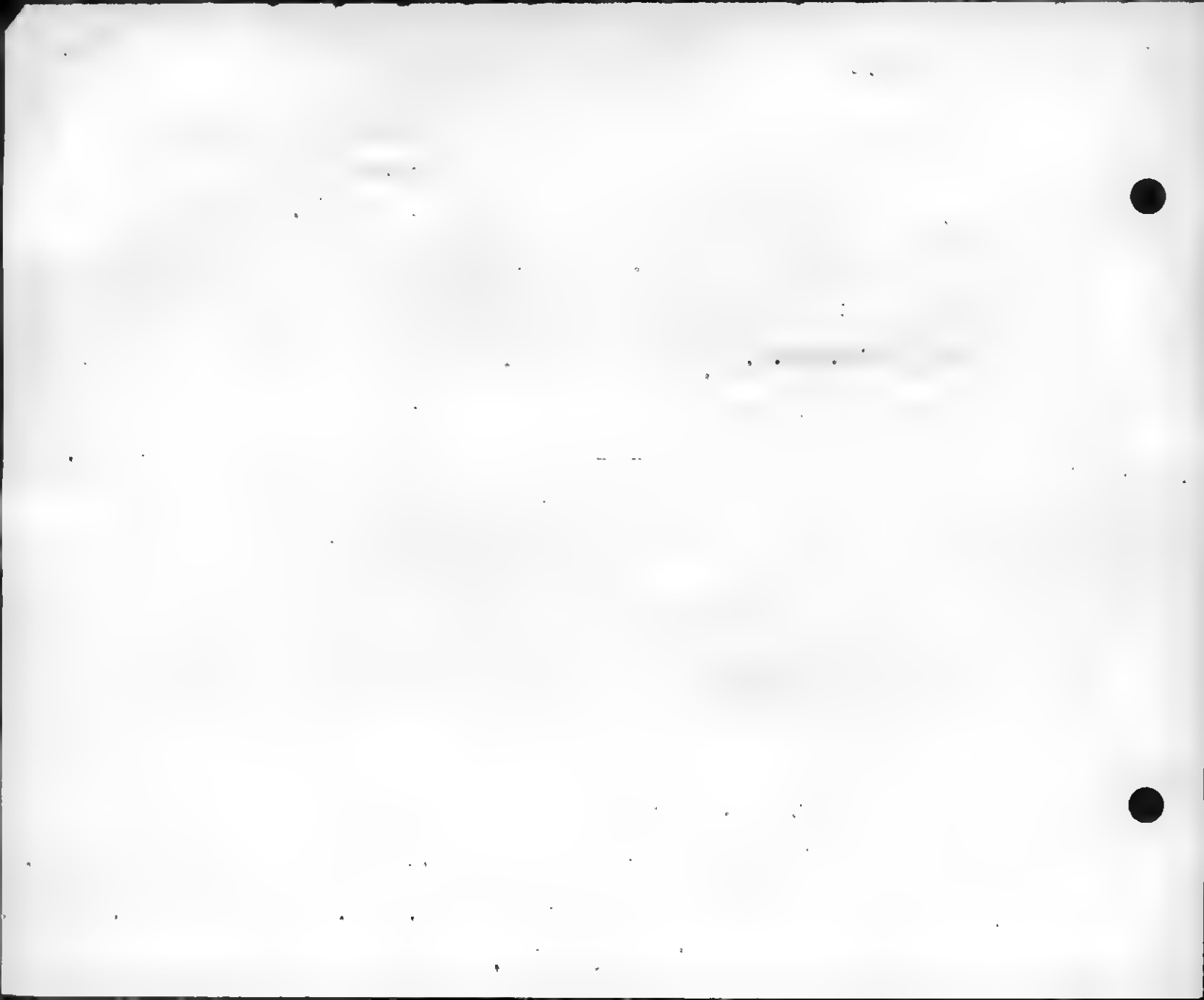
THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove section papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN ID <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		d. STREET ADDRESS <b>APT. #410 204 E. Joppa Rd., #4</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Eugene</b>		First <b>A.</b>		Middle <b>Horvath</b>		Last		4. DATE OF DEATH Month <b>2</b>		Day <b>25</b>		Year <b>1966</b>							
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-12-1908</b>		9. AGE (In years last birthday) <b>57</b> yrs.		IF UNDER 1 YEAR Months <b>57</b>		IF UNDER 24 HRS. Days <b>25</b>		Hours <b>1966</b>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Staff Asst. to V.P. and Group Exec.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Bendix Radio Div.</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Alexander Horvath</b>				14. MOTHER'S MAIDEN NAME <b>Helen Goertez</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>213-14-8039</b>				17. INFORMANT <b>Mrs. Eugene A. Horvath</b>			
								Address <b>Apt. 410 204 E. Joppa Rd., #4</b>											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pulmonary Transfusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic lung Disease</b> (c) <b>Tbc</b>																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
MEDICAL CERTIFICATION																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that <b>JD</b> (this hospital) attended the deceased from <b>2-25-66</b> , 19 <b>66</b> , to <b>2-25</b> , 19 <b>66</b> , that <b>X</b> (we) last saw the deceased alive on <b>2-25</b> , 19 <b>66</b> , and that death occurred at <b>A. M.</b> , from the causes and on the date stated above.																			
22a. SIGNATURE <b>Robert J. Mahon</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <b>2/25/1966</b>											
22c. PHYSICIAN'S NAME (Type) <b>Robert J. Mahon</b>				22d. ADDRESS <b>St. Joseph's Hospital, Towson, Md.</b>															
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>2/28/1966</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley Mem. Grds.</b>				23d. LOCATION (City, town or county) (State) <b>Timonium, Balto. Co., Md.</b>							
24. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co.</b>				ADDRESS <b>4905 York Road Balto. 12, Md.</b>				25a. REC'D BY REGISTRAR <b>FEB 28 1966</b>				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>							

1582



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

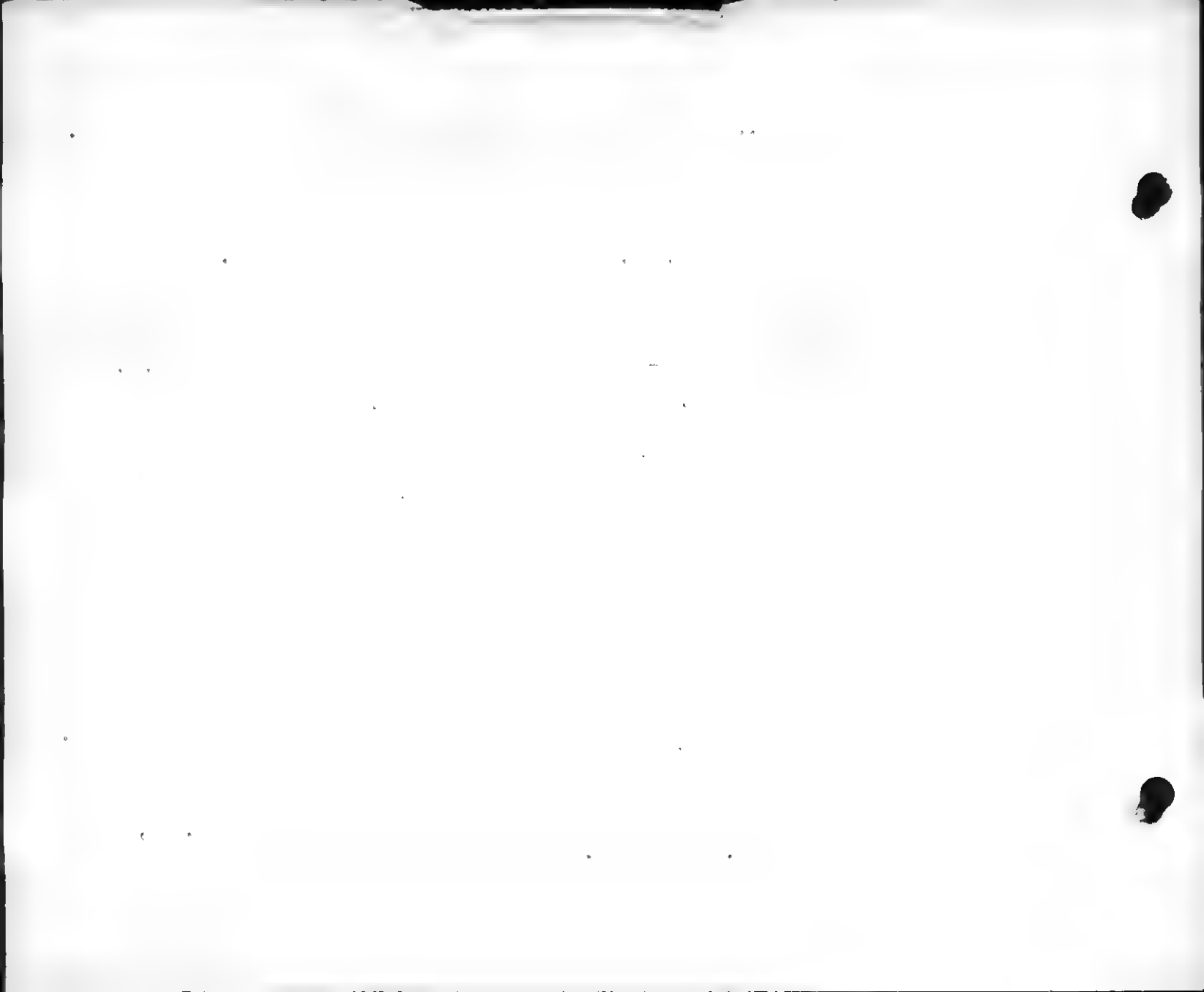
01883

FOR STATE  
HEALTH DEPT.

1 PLACE OF DEATH a. COUNTY <b>Baltimore Co.,</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, f. institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore Co. ✓</b>	
b. CITY OR TOWN (f. outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (f. outside corporate limits, write RURAL and give nearest town) <b>Baltimore 34</b>	
d. NAME OF HOSPITAL OR INSTITUTION (f. not in hospital, give street address) <b>Cub Hill, Harford Road</b>		e. STREET ADDRESS <b>2811 Northwind Road</b>	
3 NAME OF DECEASED (Type or print) <b>Gordon Miller Hott, Jr.</b>		4 DATE OF DEATH <b>Febr. 26,</b> 19 <b>66</b>	
5 SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 29, 1928</b>
9 AGE (In years birthday yrs) <b>37</b>		F UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Contractor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self-Employed</b>	
11 BIRTHPLACE (State or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>Gordon M Hott Sr.</b>		14 MOTHER'S MAIDEN NAME <b>Helen C. Bull</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <b>Yes WW II</b>		16 SOCIAL SECURITY NO <b>220-20-1987</b>	
17 INFORMANT <b>Mrs Charlotte A. Hott</b>		Address <b>Same</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carbon-monoxide poisoning.</b> DUE TO <b>7918</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Inhalation of exhaust fumes from automobile.</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>2/26 1966</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work <b>Car parking lot</b>	
20e. PLACE OF INJURY (Home, farm, factory, street off ce blag, etc.)		20f. (City or town) (County) (State) <b>Balto. Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Werner U. Spitz</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
		Address (Street, city, town, or county)	
23a. BURIAL CREMATION REMOVAL SPECIFY <b>Burial</b>	23b. DATE THEREOF <b>3/1/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore Maryland</b>
24 FUNERAL DIRECTOR <b>Leonard J Ruck Inc</b>		25a. REC'D BY REGISTRAR <b>MAF 2</b>	
ADDRESS <b>5305 Harford Rd</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AISME (5)  
SM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Randallstown</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Baltimore County Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Randallstown</b> d. STREET ADDRESS <b>Box 148 Old Court Rd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ALVIS</b> Middle <b>LEE</b> Last <b>HUGHES</b>		4. DATE OF DEATH Month <b>2</b> Day <b>9</b> Year <b>1966</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-10, 1934</b>
9. AGE (In years last birthday) <b>32</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman</b>	
11. BIRTHPLACE (State or foreign country) <b>Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert L. Hughes</b>		14. MOTHER'S MAIDEN NAME <b>Allie C. Clifton</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>42-50-8666</b>	
17. INFORMANT <b>Allie C. Hughes</b>		Address <b>Draper, N. C.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhagic shock</b> DUE TO <b>laceration of left femoral artery.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>Apparently struck by flying lumber at work</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>10:55</b> <b>2-9-66</b>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>factory</b>		20f. (City or town) (County) (State) <b>Randallstown Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Rudiger Breitenecker, M.D.</b> EXAMINER'S NAME (Type)		22. DATE SIGNED <b>2-9-66</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb 12, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Hughes Family Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Patrick, Co; Va.</b>	
24. FUNERAL DIRECTOR <b>LORING BYERS</b> ADDRESS <b>8728 Liberty Road Randallstown, Md.</b>		25a. REC'D BY REGISTRAR <b>FEB 14 1966</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

SC 4 12 12

...

...

...

... of

...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

B.P.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

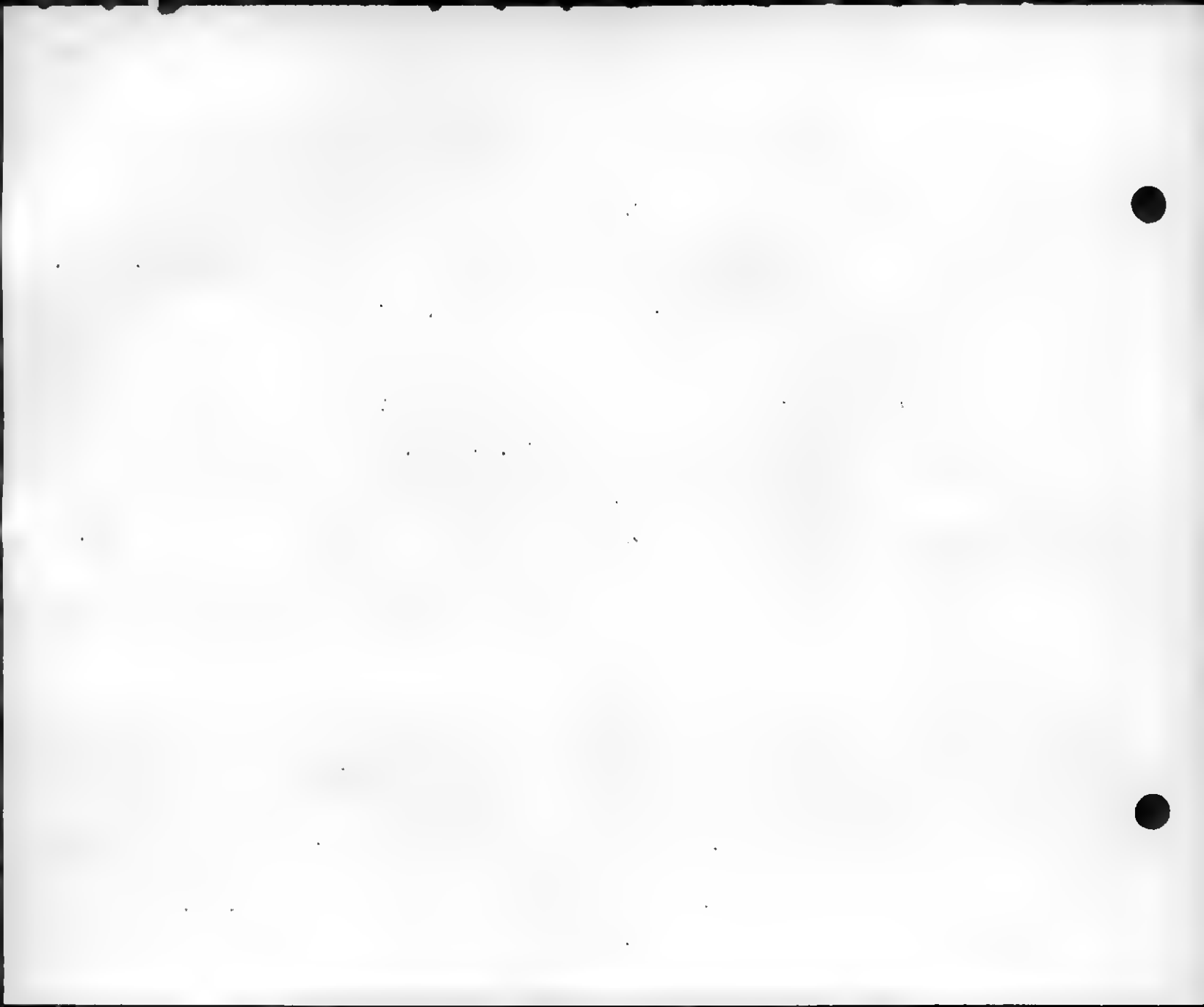
CERTIFICATE OF DEATH

01937

Item of rain 67/4 2/20/66 mh

01585

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Woodlawn</b>		d. STREET ADDRESS <b>9 Northland Road 7</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <b>Stella Jeannette Hughes</b>		4. DATE OF DEATH <b>February 16, 1966</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1874 Jan 3, 1874</b>		9. AGE (In years last birthday) <b>92 yrs.</b>											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>? Peters</b>		14. MOTHER'S MAIDEN NAME <b>? Howard</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No None</b>											
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. Orin L. Hughes</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocardial infarction</b> DUE TO (b) <b>generalized arteriosclerosis</b> DUE TO (c) <b>1221</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 hr.</b> <b>153 hr.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20d. (City or town) (County) (State)		20e. (City or town) (County) (State)		20f. (City or town) (County) (State)		20g. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <b>9-27-</b> , 1965, to <b>2-16</b> , 1966, that (I) (we) last saw the deceased alive on <b>2-15-</b> , 1966, and that death occurred <b>1230 P.M.</b> from the causes and on the date stated above.												22a. SIGNATURE <b>Wilmer K. Gallagher Jr.</b>		22b. DATE SIGNED <b>2-17-66</b>		22c. PHYSICIAN'S NAME (Type) <b>Wilmer K. Gallagher</b>		22d. ADDRESS <b>6209 Frederick Ave. 21228 Balt. Md.</b>		22e. REC'D BY REGISTRAR <b>FEB 18 1966</b>		22f. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/18/1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Woodlawn, Md.</b>		23e. REC'D BY REGISTRAR <b>FEB 18 1966</b>		23f. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		23g. REC'D BY REGISTRAR <b>FEB 18 1966</b>											
24. FUNERAL DIRECTOR <b>Wm. J. Tickner &amp; Sons</b>		24b. ADDRESS <b>Baltimore, Md. 117 North E. Ave.</b>		24c. REC'D BY REGISTRAR <b>FEB 18 1966</b>		24d. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		24e. REC'D BY REGISTRAR <b>FEB 18 1966</b>		24f. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		24g. REC'D BY REGISTRAR <b>FEB 18 1966</b>											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

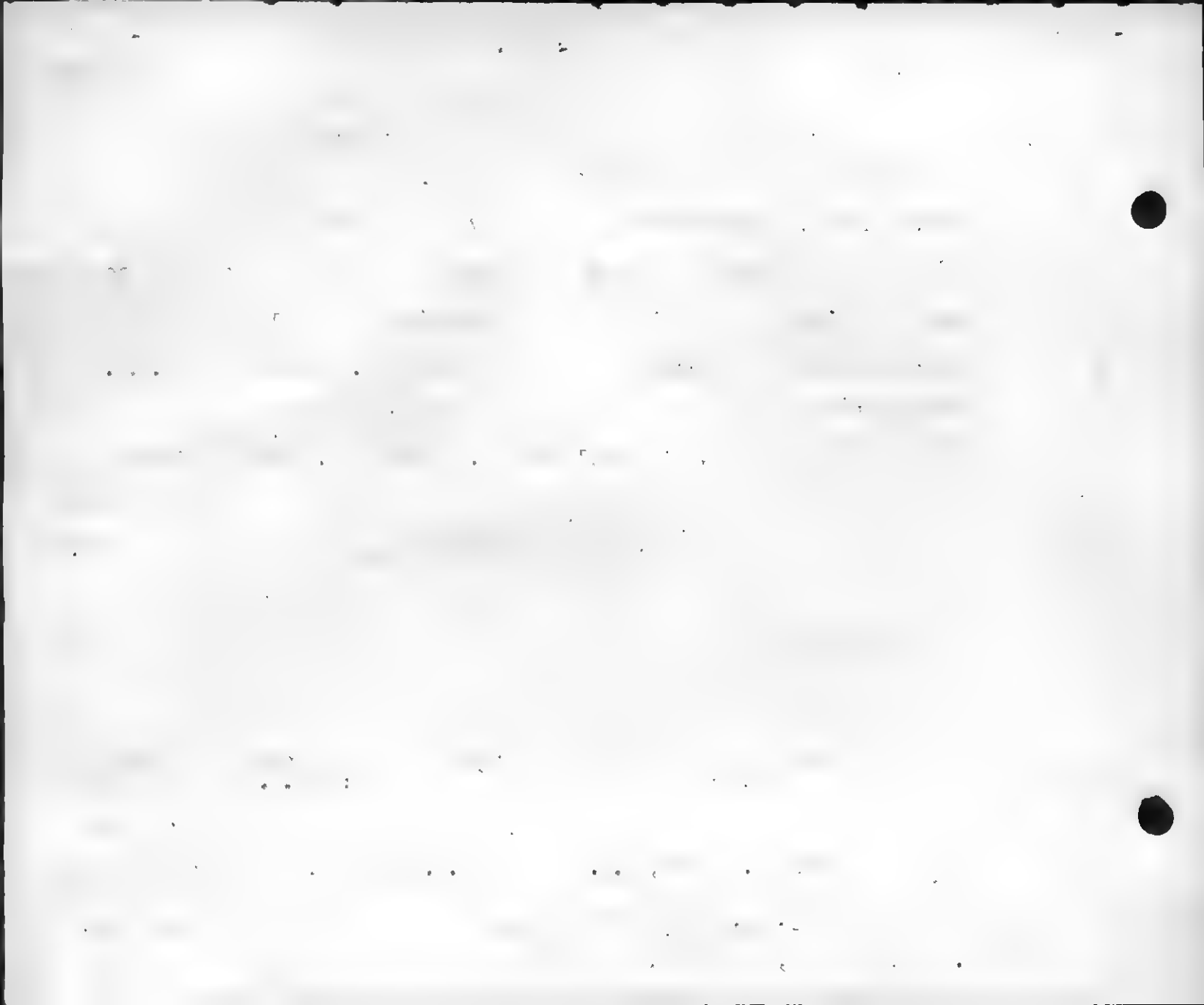
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

01938

01886

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b> c. LENGTH OF STAY IN 1b <b>59 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <b>MARYLAND</b> f. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> g. STREET ADDRESS <b>75 WICKHAM ROAD</b> h. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CARRIE</b> Middle <b>EDNA</b> Last <b>HURST</b>		4. DATE OF DEATH Month <b>2</b> Day <b>19</b> Year <b>19 66</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/21/84</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>REGISTERED NURSE</b>		9b. KIND OF BUSINESS OR INDUSTRY <b>NURSING</b>	9. AGE (In years last birthday) <b>81</b> yrs. IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> IF UNDER 24 HRS.: Hours <b>0</b> Min. <b>0</b>
10. FATHER'S NAME <b>WILLIAM GERWIG</b>		11. BIRTHPLACE (County & State, or foreign country) <b>HOWARD CO. MARYLAND</b>	
12. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> (If yes give war or dates of service) <b>WW I</b>		13. SOCIAL SECURITY NO. <b>373 10 71 00</b>	
14. MOTHER'S MAIDEN NAME <b>ISABELLE ISAAC</b>		15. INFORMANT <b>VETERANS HOSPITAL</b> Address <b>CLIN. RECORDS, FT. HOWARD, MARYLAND</b>	
16. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> <b>1420</b> DUE TO (b) <b>CARCINOMA PAROTID GLAND</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) <b>METASTASIS TO LIVER AND SPLEEN</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 DAYS</b> <b>2 YEARS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>PULMONARY EDEMA</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>12/22</b> , 19 <b>65</b> to <b>2/19</b> , 19 <b>66</b> that (I) (we) last saw the deceased alive on <b>2/19</b> , 19 <b>66</b> , and that death occurred at <b>12:30 p.m.</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>LOUIS E. KIMMEL, M.D.</b>		22b. DATE SIGNED <b>2/19/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>LOUIS E. KIMMEL, M.D.</b>		22d. ADDRESS <b>V.A. HOSPITAL, FORT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Feb. 23, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>NATIONAL ADDRESS AVENUE</b>	23d. LOCATION (City, town or county) (State) <b>BALTIMORE 28, MARYLAND</b>
24. FUNERAL DIRECTOR <b>G. TRUMAN SCHWAB, BALTIMORE, MARYLAND</b>		25a. REC'D BY REGISTRAR <b>FEB 23 1966</b> 25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

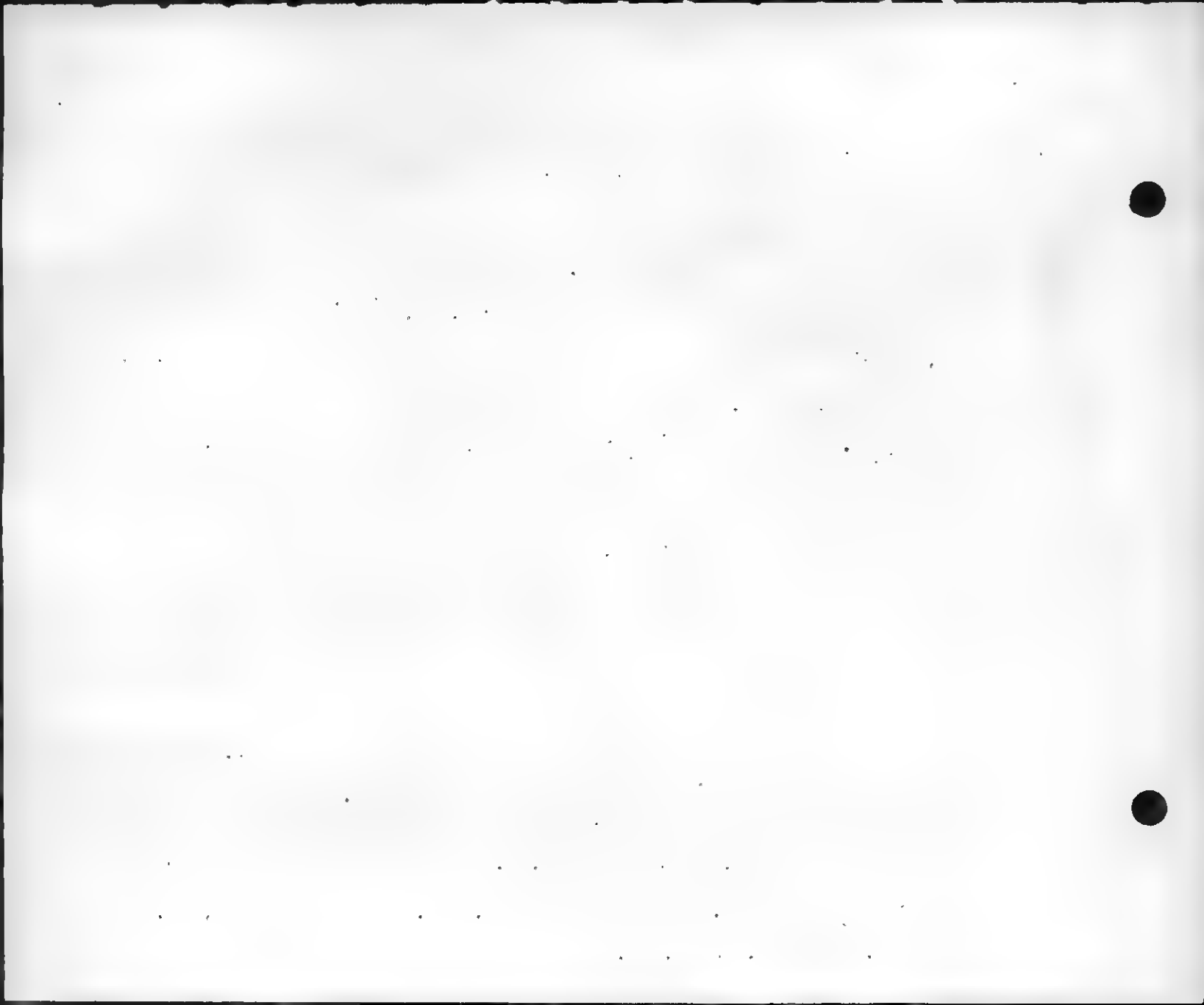


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN ID <b>10mth 7dys</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Middle River</b> d. STREET ADDRESS <b>1214 Third Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Charles A. Immler</b>		4. DATE OF DEATH <b>February 15 1966</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 16, 1876</b>
9a. AGE (In years last birthday) <b>89</b> yrs.		9b. IF UNDER 1 YEAR: Months <b>1</b> Days <b>15</b> Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>U. S.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Charles A. Immler</b>		14. MOTHER'S MAIDEN NAME <b>Caroline Klein</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-28-4198</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> <b>4200</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pneumonia</b>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED while <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <del>to</del> (this hospital) attended the deceased from <b>April 8, 1965</b> , to <b>Feb. 15, 1966</b> , that (1) <del>the</del> last saw the deceased alive on <b>Feb. 15, 1966</b> , and that death occurred at <b>11:20</b> M. from the causes and on the date stated above.			
22a. SIGNATURE <b>Stella Wachsler</b>		22b. DATE SIGNED <b>2-15-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Stella Wachsler, M. D.</b>		22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>2/17/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem. Cem.</b>	23d. LOCATION (City, town or county) (State) <b>Elkridge, Md.</b>
24. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc. Balto. Md. 21214</b>		25a. REC'D BY REGISTRAR <b>FEB 16 1966</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

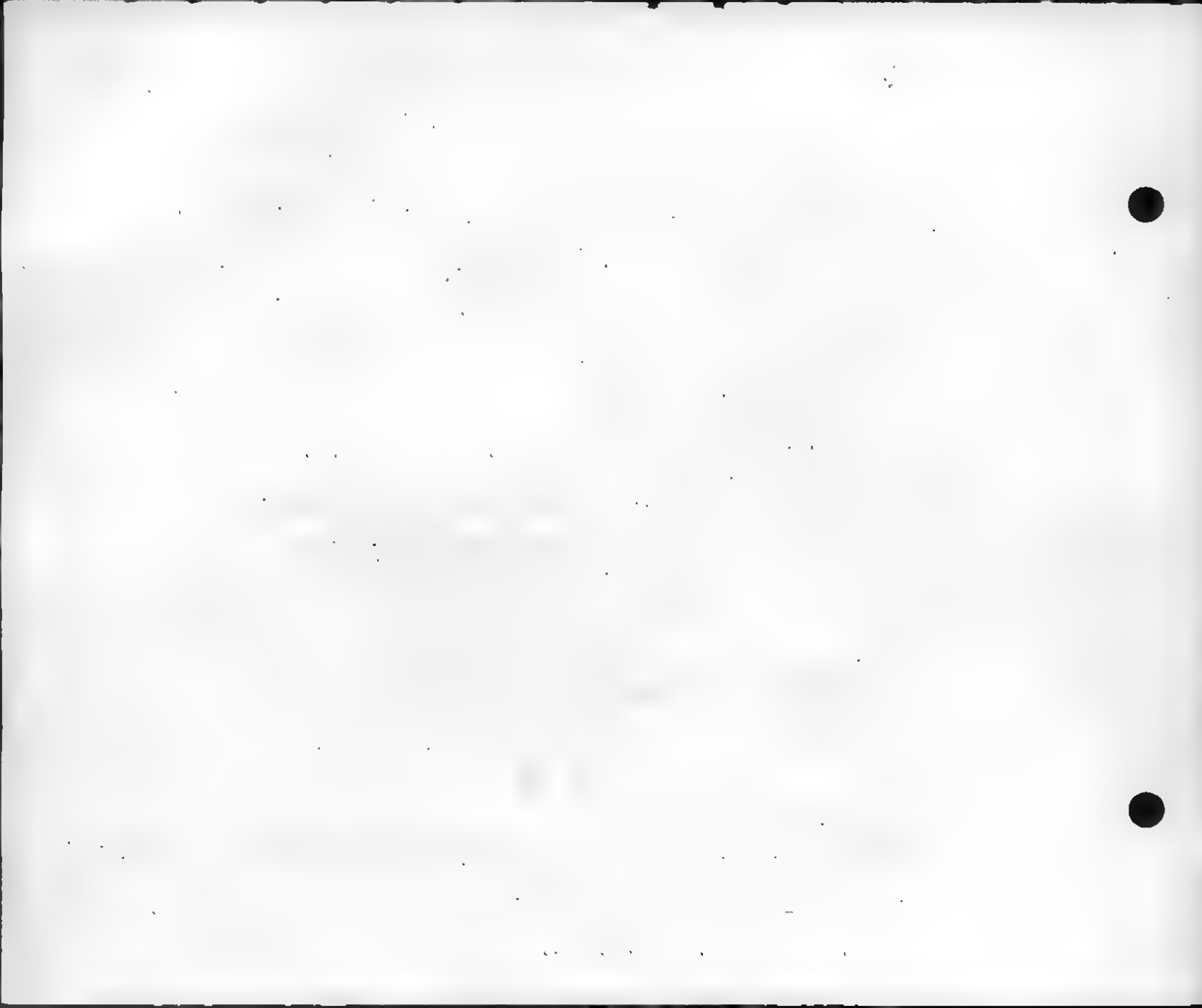


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
01940		Items 13, 14, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100						01888			
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>				b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>				c. LENGTH OF STAY IN 1b <u>Maryland</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>2219 Wilker Avenue</u>				e. STREET ADDRESS <u>3422 Northern Parkway</u>				f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Aubrey H. Ensley</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>8</u> Year <u>1966</u>							
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 13, 1898</u>		9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>				11b. KIND OF BUSINESS OR INDUSTRY <u>Bakery</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>William G. Ensley</u>				14. MOTHER'S MAIDEN NAME <u>Maria Pritchard</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>139050170</u>		17. INFORMANT <u>Mr. William G. R. Ensley</u>				Address <u>W. 101 Y, "J"</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>4201</u> DUE TO (b) <u>infarction of myocardium due to</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
21c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>				21d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		21f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>July 15, 1965</u> to <u>Feb 8, 1966</u> , that (I) (we) last saw the deceased alive on <u>Feb 1, 1966</u> , and that death occurred at <u>10:20 A.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Donald W. Mintzer</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		DATE SIGNED <u>Feb 9 1966</u>					
22c. PHYSICIAN'S NAME (Type) <u>Donald W. MINTZER</u>				22d. ADDRESS <u>3009 ELLERGREEN AVE BALTO, MD</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-12-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>					
24. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc. Balto. Md. 21214</u>				25a. REC'D BY REGISTRAR <u>FEB 11 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

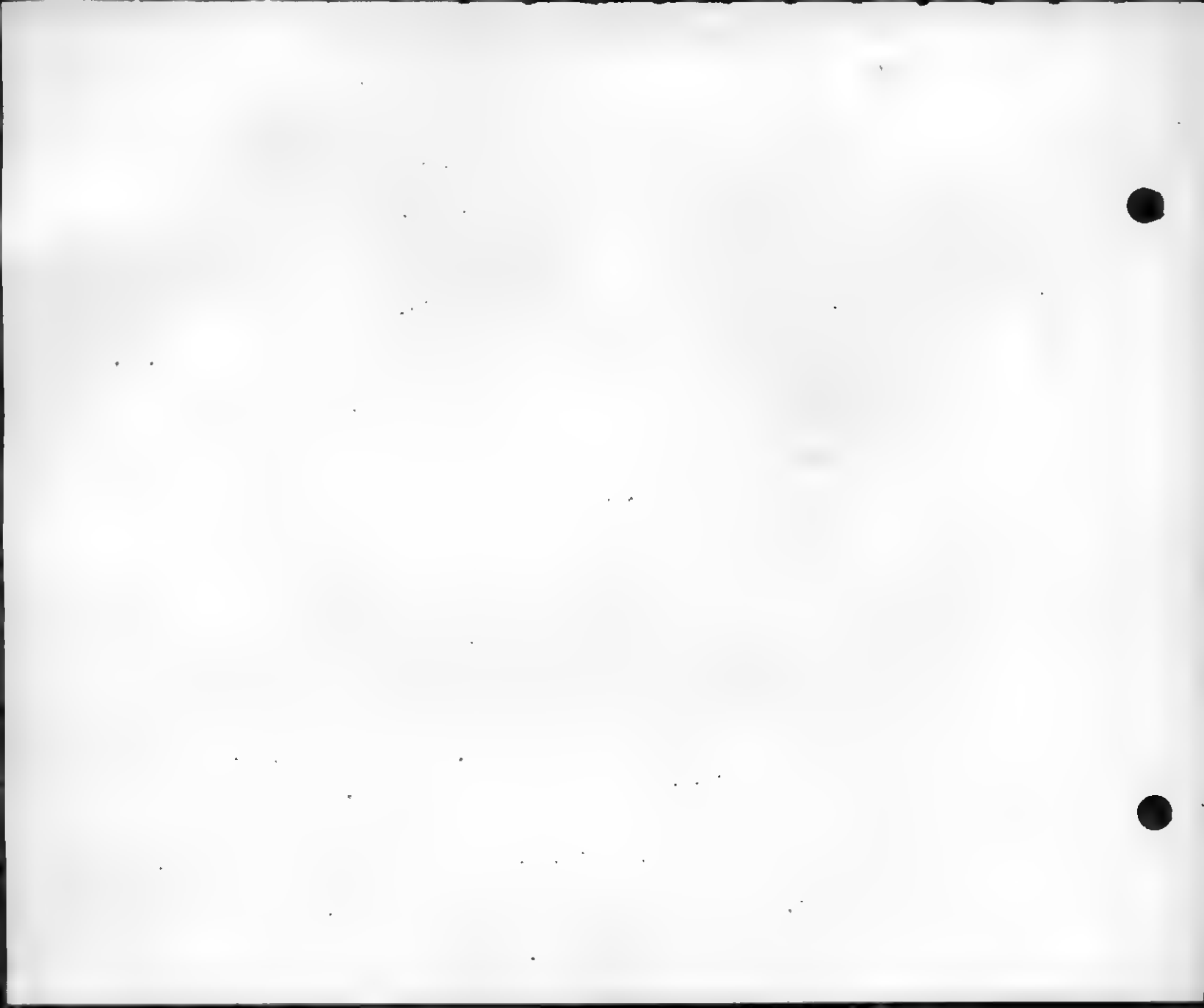
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and at any event, within 72 hours after death.

VR A15 (4)  
2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>3mth25dys</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Jacoba</b> Middle <b>Jenezen</b> Last <b>Jenezen</b>		4. DATE OF DEATH Month <b>February</b> Day <b>8</b> Year <b>1966</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 15, 1901</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	9. AGE (In years last birthday) <b>64</b> yrs.
11. BIRTHPLACE (County & State, or foreign country) <b>Holland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>John Van Duyn</b>		14. MOTHER'S MAIDEN NAME <b>Marie Van Der Venne</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>unknown None</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Bedsore</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic heart disease</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <del>the</del> (this hospital) attended the deceased from <b>Oct. 6, 1965</b> to <b>Feb. 8, 1966</b> , that <del>he</del> (we) last saw the deceased alive on <b>Feb. 8, 1966</b> , and that death occurred at <b>4:45</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Dennis D. Agallianos</b>		22b. DATE SIGNED <b>P. 4-45</b>	
22c. PHYSICIAN'S NAME (Type) <b>DENNIS D. AGALLIANOS</b>		22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Feb. 11, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley Memorial Ins. Cockeysville, Maryland</b>	23d. LOCATION (City, town or county) (State)
24. FUNERAL DIRECTOR <b>John Burns Sons, Towson, Md.</b>		25a. RECEIVED BY REGISTRAR <b>FEB 14 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		DATE	

MEDICAL CERTIFICATION



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a certificate, noting the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

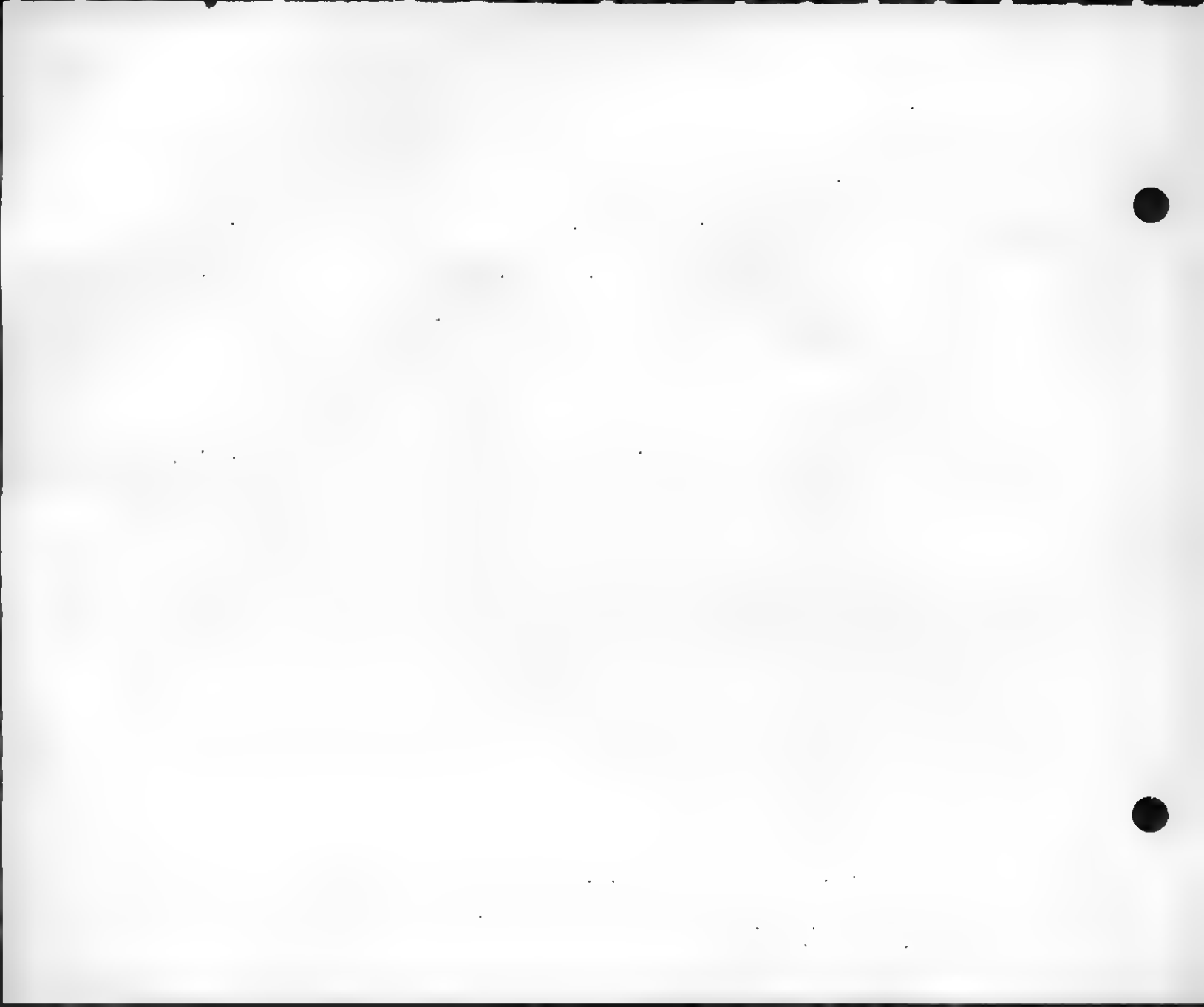
Items 18-21 Film G374

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01942

01890

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>				d. STREET ADDRESS <b>4514 WOODLEA AVENUE</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>GILBERT E. JEWELL</b>				4. DATE OF DEATH Month Day Year <b>FEBRUARY 25 1966</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-29-17</b>	
9. AGE (in years last birthday) <b>48 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Home Repairs</b>			
13. FATHER'S NAME <b>JOHN JEWELL</b>				14. MOTHER'S MAIDEN NAME <b>EDNA FORRESTER</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WWII</b>		16. SOCIAL SECURITY NO. <b>217 05 7965</b>		17. INFORMANT Address <b>Clin. Records, VA Hospital, Ft. Howard, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic pyelonephritis complicating</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>fractures of right femur and right wrist.</b> due to (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b>							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell from ladder</b>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>10/25 1965</b>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>House-36th Street Baltimore</b>		20f. (City or town) (County) (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Russell S. Fisher</i>		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				22. DATE SIGNED <b>2-28-66</b>	
EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b>		Address (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/28/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b> <b>3331 Brehms Lane</b>				25a. REC'D BY REGISTRAR <b>MAR 1 1966</b>			
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

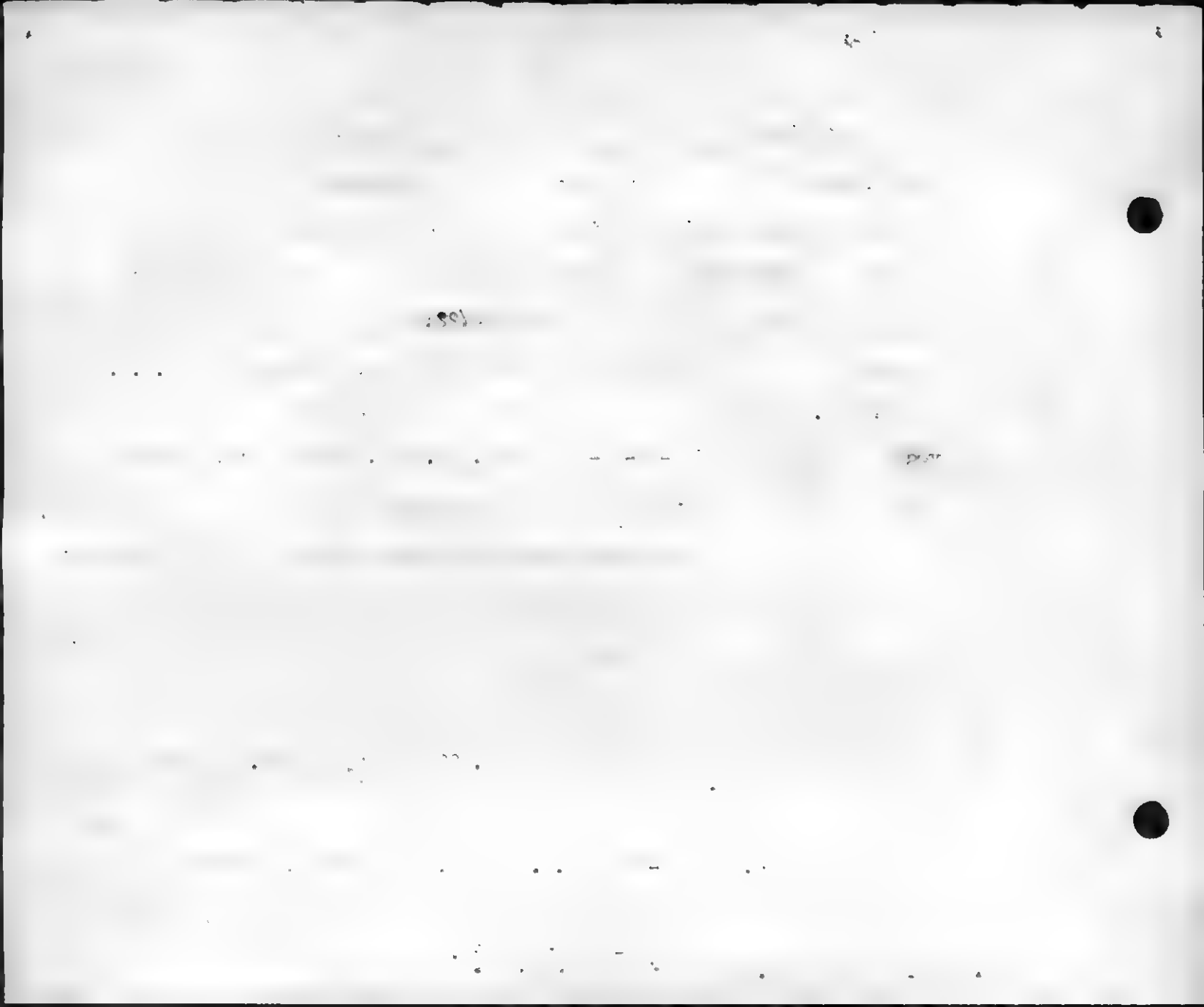


**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN 1b <b>91 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>1920 Eutaw Place</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>NICODEMUS JAMES JOHNSON</b>		4. DATE OF DEATH Month Day Year <b>FEBRUARY 21 1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>10/22/24</b>
9. AGE (In years (last birthday)) <b>41</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Confectionery Store Baltimore, Maryland</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas John T. Johnson</b>		14. MOTHER'S MAIDEN NAME <b>Pearl Johnson</b>	
15. WAS DECEASED EVER IN U.S. ARMY FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW II</b>		16. SOCIAL SECURITY NO. <b>215-18-69-83</b>	
17. INFORMANT <b>Clin. Rec. VAH, Fort Howard, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PNEUMONIA; PULMONARY EDEMA</b> 145X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b> DUE TO (c) <b>UNKNOWN</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <del>NO</del> (this hospital) attended the deceased from <b>Nov. 22 1965</b> to <b>Feb. 21 1966</b> , that (we) last saw the deceased alive on <b>Feb. 21 1966</b> , and that death occurred at <b>1:15 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <i>Alicia O. Menendez-Ross</i>		22b. DATE SIGNED <b>2/22/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>ALICIA O. MENDEZ-ROSS, M.D.</b>		22d. ADDRESS <b>VAH, FORT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>2-25-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>National Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR <b>Morton &amp; Dyett Fun. Home</b>		25a. REC'D BY REGISTRAR <b>DATE FEB 23 1966</b>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reinsert carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

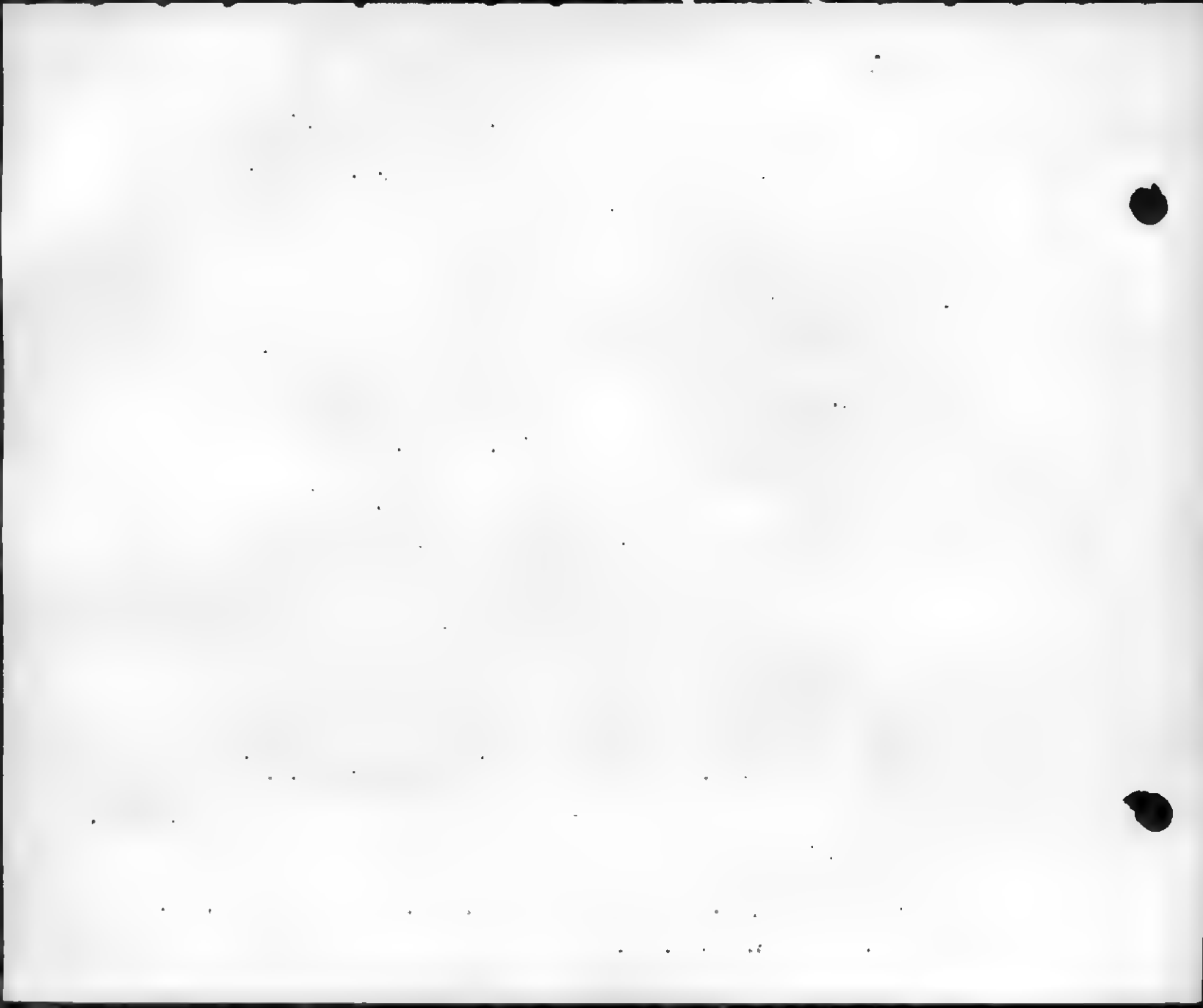
VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

01944

01892

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>		c. LENGTH OF STAY IN 1b <u>21 hrs.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>GREATER BALTIMORE Medical Center</u>				d. STREET ADDRESS <u>524 E. 30th St. #18</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>Jerome</u> Last <u>Jones</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>15</u> Year <u>1966</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/3/02</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY <u>RETIRED Board of Education</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Pittsburgh, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>DAVID JONES</u>				14. MOTHER'S MAIDEN NAME <u>TESSIER, Easter</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>(If yes give war or dates of service)</u>		17. INFORMANT <u>Mrs. Mary M. Jones</u>		Address <u>(Same)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure, sec. to chronic lung disease</u> DUE TO (b) <u>Pneumonia</u> DUE TO (c) <u>bronchopneumonia</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						INTERVAL BETWEEN ONSET AND DEATH <u>3 WEEKS</u>	
						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 15, 1966</u> , to <u>Feb. 15, 1966</u> , that (I) (we) last saw the deceased alive on <u>Feb. 15, 1966</u> , and that death occurred at <u>11:10</u> on the causes and on the date stated above.							
22a. SIGNATURE <u>Reynaldo C. Guzman</u>				22b. DATE SIGNED <u>2/15/66</u>		22c. PHYSICIAN'S NAME (Type) <u>REYNALDO C. GUZMAN</u>	
22d. ADDRESS <u>G.B.M.C.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/19/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Mem. Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Elkridge, Md.</u>	
24. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc. Balto. Md. 21214</u>				25a. REC'D BY REGISTRAR <u>DATE FEB 16 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of the body in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

1 (M)

01946

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

01894

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b> c. LENGTH OF STAY IN ID <b>26 yrs.</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Res., 827 S. 50th Street</b>				d. STREET ADDRESS <b>827 S. 50th St. 21222</b>			
3. NAME OF DECEASED (Type or print) <b>LOUIS JUNG</b>				4. DATE OF DEATH <b>Feb. 3-1966</b> 19 <b>66</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 23-1901</b> 64 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Machinists</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bethlehem Steel Co.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Conrad Jung</b>				14. MOTHER'S MAIDEN NAME <b>Mary Faber</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Wife, Mrs. Alma Jung, # 2,a,b,c,d</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CA of LUNG (left) - C Metastasis</b> DUE TO (b) <b>6 mos.</b> DUE TO (c) <b>10A-S-C-V-Disease (2D) Diabetes Mellitus</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>August</b> , 19 <b>65</b> , to <b>Feb 3</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>Feb 2</b> , 19 <b>66</b> , and that death occurred at <b>9:00</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>M B Davis</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <b>Melvin B. Davis M.D.</b>				22d. ADDRESS <b>6800 Morningson Rd. Dundalk, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 7-1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn</b>		23d. LOCATION (City, town or county) (State) <b>7225 Eastern Ave. Balto. Md</b>	
24. FUNERAL DIRECTOR <b>JOHN J. DUDA, Dundalk, Md. 21222</b>				25a. REC'D BY REGISTRAR <b>FEB 7 1966</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

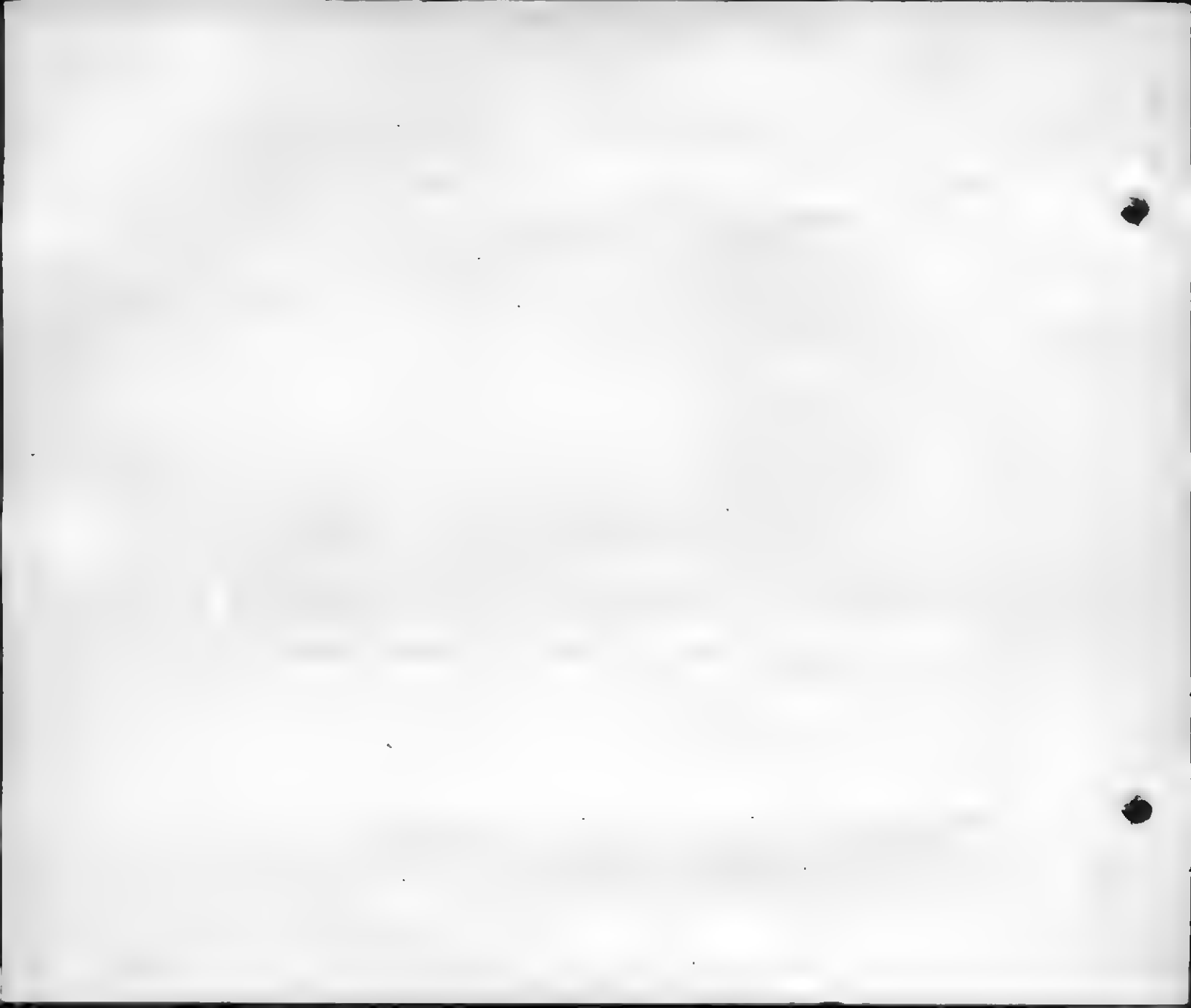
## CERTIFICATE OF DEATH

Reg. Dist. No. 01895

01947

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KEENWOOD</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KEENWOOD</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5001 KEENWOOD AVE.</u>			d. STREET ADDRESS <u>5001 KEENWOOD AVE.</u>		
3. NAME OF DECEASED (Type or print) <u>FREDERICK</u> First Middle Last			4. DATE OF DEATH <u>FEB 15 1966</u> Month Day Year		
5. SEX <u>M</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 11, 1909</u>	9. AGE (In years last birthday) <u>61</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CARPENTER</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE COUNTY</u>	
13. FATHER'S NAME <u>CHARLES KAHLER</u>			14. MOTHER'S MAIDEN NAME <u>EMMA ELLIGSON</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212-01-9146</u>		17. INFORMANT <u>MRS FREDERICK KAHLER 5001 KEENWOOD AVE</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO (b) <u>arterio-sclerotic Cardiovascular</u> DUE TO (c) <u>hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>10 y-2</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>Jan 1</u> , 19 <u>66</u> , to <u>Feb 15</u> , 19 <u>66</u> , that I last saw the deceased alive on <u>Feb 15</u> , 19 <u>66</u> , and that death occurred at <u>10 P</u> M, from the causes and on the date stated above					
ACTUAL SIGNATURE <u>G. M. Baumgardner</u> M.D.			ADDRESS (Street, city or town, state) <u>BALTIMORE</u> DATE SIGNED <u>2/16/66</u>		
PHYSICIAN'S NAME (Type) <u>G. M. BAUMGARDNER</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>FEB 18, 1966</u>		22c. NAME OF CEMETERY OR CREMATORY <u>7 ON CROFT</u>	
22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD.</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph F. ...</u> ADDRESS <u>...</u>			24. REG'D BY REGISTRAR <u>FEB 18 1966</u> 24b. REGISTRAR'S SIGNATURE <u>...</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



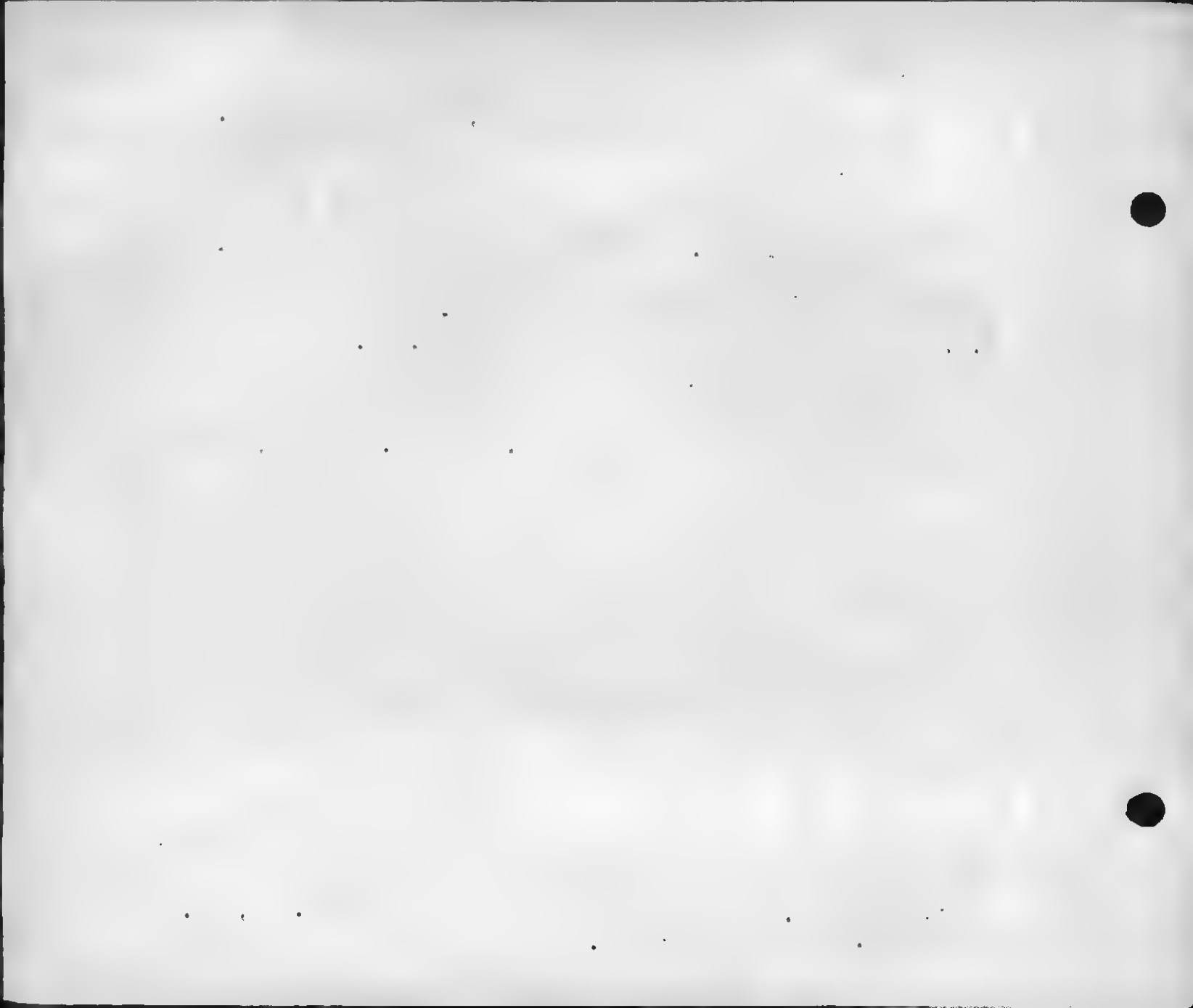
# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

### CERTIFICATE OF DEATH

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN b. <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>648 Aldershot Rd</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> d. STREET ADDRESS <u>648 Aldershot Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Juliana E. Kappler</u>		<b>4. DATE OF DEATH</b> Month <u>Feb.</u> Day <u>13</u> Year <u>1966</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <u>Nov. 28/87</u>	
<b>9. AGE</b> (In years last birthday) <u>78</u> yrs.		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>H.W.</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Own Home</u>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Balto. Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>		<b>13. FATHER'S NAME</b> <u>John Frederick Hegler</u>	
<b>14. MOTHER'S MAIDEN NAME</b> <u>Fredericka Roeder</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown)		<b>16. SOCIAL SECURITY NO.</b>	
<b>17. INFORMANT</b> <u>Mrs. Henry C. Tiemeyer, 648 Aldershot Rd</u>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio-sclerotic Cardio-vascular disease</u> <u>4221</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>_____</u> DUE TO (c) <u>_____</u> DUE TO (e), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)					
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>		<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)		<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>a.m.</u> <u>19</u>			
<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from <u>1935</u>, 19<u>  </u>, to <u>13 Feb</u>, 19<u>66</u> that (I) (we) last saw the deceased alive on <u>12 Feb</u>, 19<u>66</u>, and that death occurred at <u>2:30 PM</u>, from the causes and on the date stated above.</b>					
<b>22a. SIGNATURE</b> <u>J. E. Proctor</u>		<b>22b. DATE SIGNED</b> <u>15 Feb 66</u>		<b>22c. PHYSICIAN'S NAME (Type)</b>	
<b>22d. ADDRESS</b> <u>104 W. Madison St. Balto, Md 1</u>		<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>burial</u>			
<b>23b. DATE THEREOF</b> <u>Feb. 16/66</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Woodlawn</u>		<b>23d. LOCATION (City, town or county)</b> (State) <u>Balto. 7, Md.</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>itzke F.D. 4101</u>		<b>25a. REC'D BY REGISTRAR</b>		<b>25b. REGISTRAR'S SIGNATURE</b>	
<b>25c. ADDRESS</b> <u>Edmondson Ave.</u>		<b>DATE</b> <u>Feb 15 1966</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

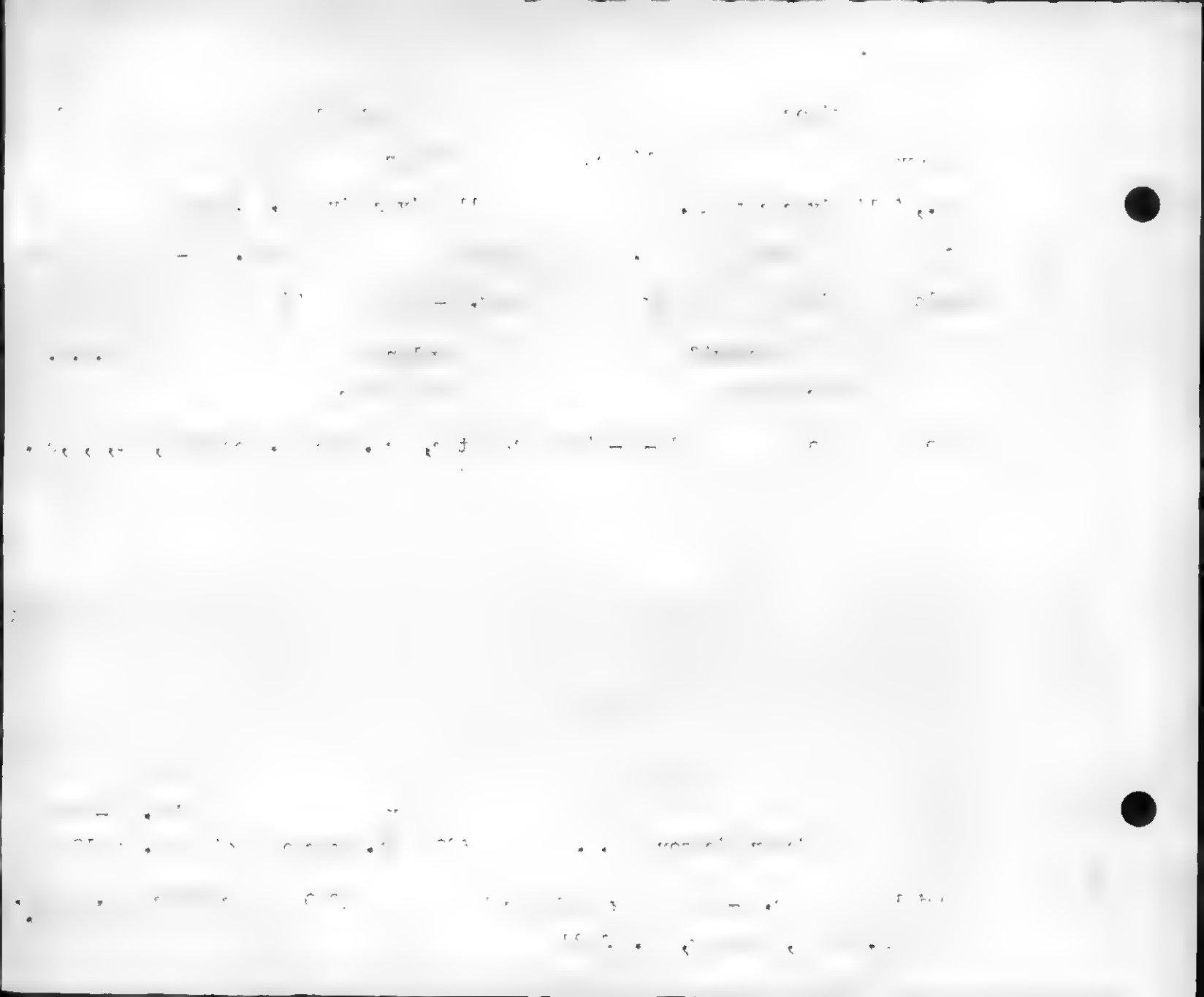


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ZOM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edgemere</b>			c. LENGTH OF STAY IN 1b <b>16 yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edgemere</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Res., 7114 Riverdrive Rd.</b>					d. STREET ADDRESS <b>7114 Riverdrive Rd. 21219</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>C.</b> Last <b>KAVANAGH</b>					4. DATE OF DEATH Month <b>Feb.</b> Day <b>26</b> Year <b>19 66</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 3-1891</b>		9. AGE (In years last birthday) <b>74</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Edward Smith</b>					14. MOTHER'S MAIDEN NAME <b>Anna Kulter</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>219-26-2475</b>		17. INFORMANT Address <b>Daughter, Mrs. Mary C. Donnelly, #2, a, b, c, d.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma</b> <b>172x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma Fundus of Uterus</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									INTERVAL BETWEEN ONSET AND DEATH <b>6 mos.</b> <b>6 years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>May</b> , 19 <b>60</b> , to <b>Feb 26</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>Feb 26</b> , 19 <b>66</b> , and that death occurred at <b>8 AM</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>Roger Windsor</b> M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Feb. 28-1966</b>		
22c. PHYSICIAN'S NAME (Type) <b>Roger Windsor M.D.</b>					22d. ADDRESS <b>520 D St. Sparrows Point Md. 21219</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>Mar. 1-1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>		23d. LOCATION (City, town or county) (State) <b>4300 Old Frederick Rd. Balto.</b>		
24. FUNERAL DIRECTOR <b>JOHN J. DUDA, Dumdalk, Md. 21222</b>					25a. REC'D BY REGISTRAR <b>MAR 1 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		



FOR STATE  
HEALTH DEPT.

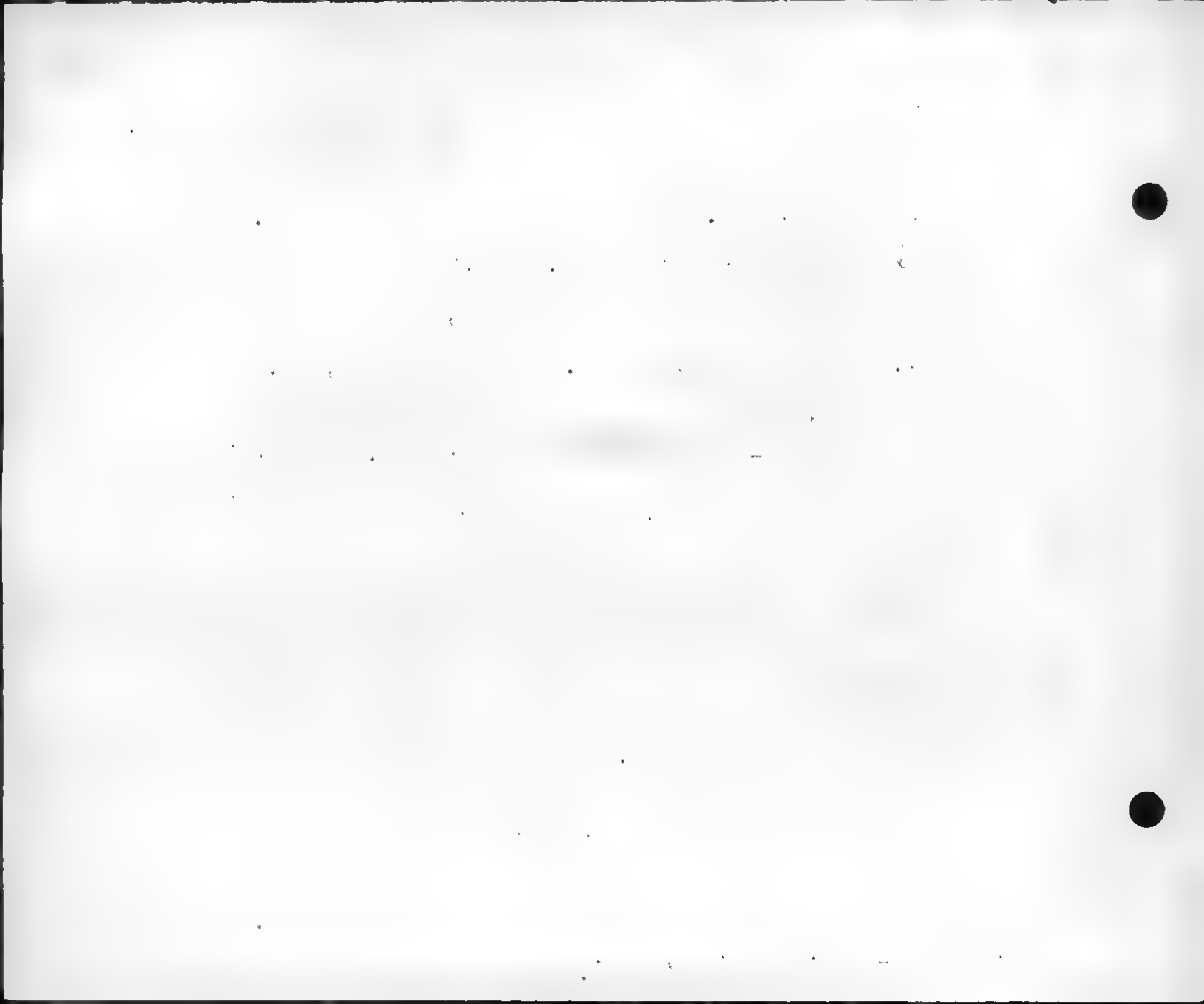
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01598

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>62 Burkshire Rd. 21204</b>		d. STREET ADDRESS <b>62 Burkshire Rd. 21204</b>	
3. NAME OF DECEASED (Type or print) <b>GERTRUDE ELIZABETH KEEN (Bessie)</b>		4. DATE OF DEATH Month <b>2</b> / Day <b>10</b> / Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 1, 1897</b>
9. AGE (In years last birthday) <b>68</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> / Days <b>0</b> / Hours <b>0</b> / Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sec'y.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>State of Md.</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thomas S. Keen</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Reese</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>218-22-028</b>	
17. INFORMANT <b>Miss Blance E. Keen (Sister)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. OUE TO (b) OUE TO (c)		18. CONTINUATION OF CAUSE OF DEATH <b>Coronary Occlusion</b> INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> / p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles F. H. Donnell</b>		22. DATE SIGNED <b>2/10/66</b>	
EXAMINER'S NAME (Type) <b>Charles F. H. Donnell</b>		22. DATE SIGNED <b>2/10/66</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/14/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Louisa Park</b>		23d. LOCATION (City, town or county) (State) <b>Balto.</b>	
24. FUNERAL DIRECTOR <b>Mitchell-Wiedefeld Home, Inc.</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>FEB 15 1966</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

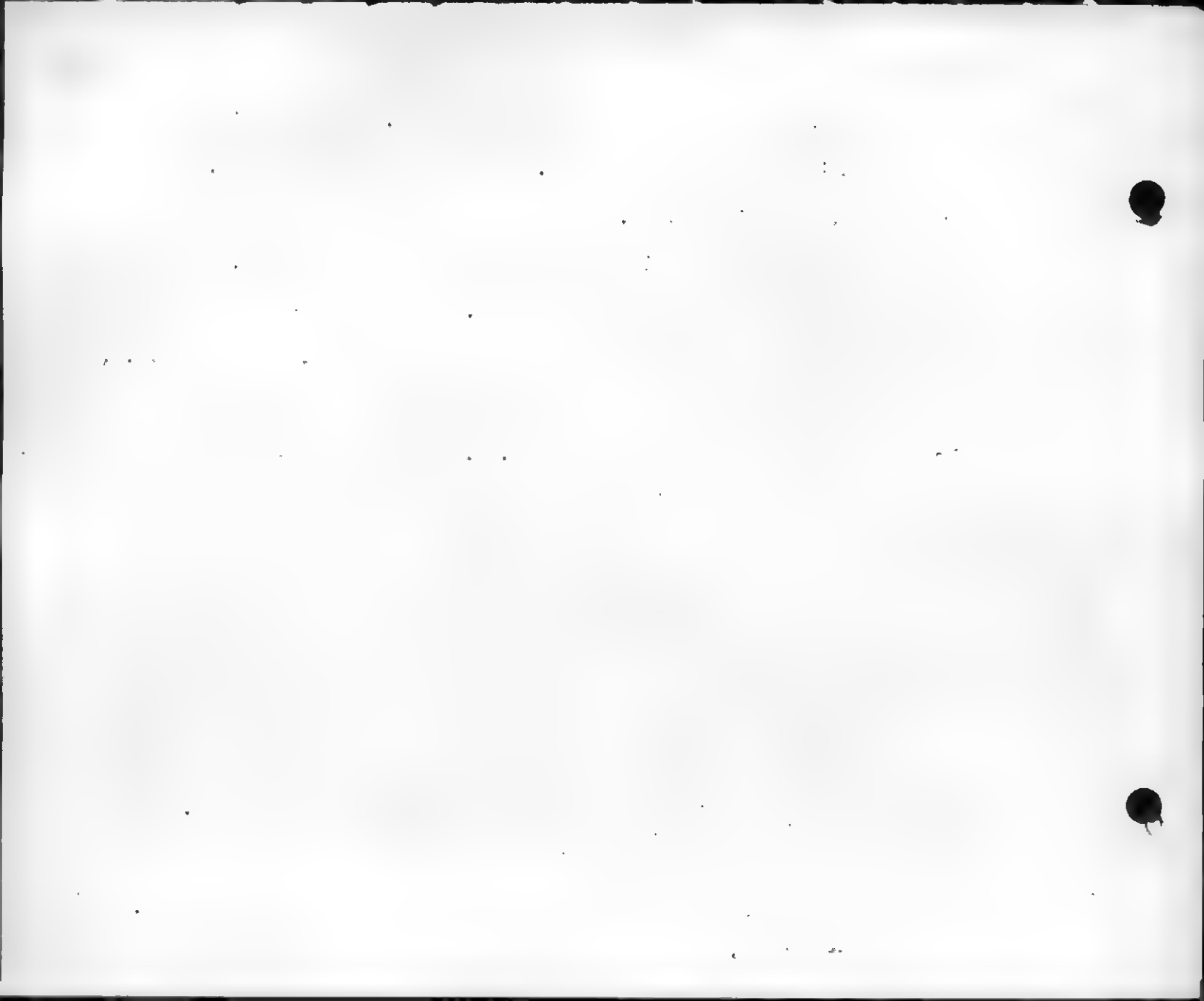
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>			c. LENGTH OF STAY IN 1b <u>60 yrs.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pikesville 8, Md.</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Hooks Lane, Pikesville 8, Md.</u>					d. STREET ADDRESS <u>Hooks Lane</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Martha</u> Middle <u>Ellen</u> Last <u>Keir</u>			4. DATE OF DEATH Month <u>Feb.</u> Day <u>6,</u> Year <u>1966</u>						
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 6, 1875</u>		9. AGE (In years last birthday) <u>90</u> yrs. IF UNDER 1 YEAR: Months <u></u> Days <u></u> IF UNDER 24 HRS: Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John O'Neal</u>					14. MOTHER'S MAIDEN NAME <u>Hammondtree</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mr. W. Gladstone Keir, Hooks Lane, Pikesville 8</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease</u> 4 a.m. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <u>few years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour <u></u> a.m. <u>19</u> p.m. <u></u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>1948</u> , to <u>6 Feb</u> , 19 <u>66</u> , that (I) <del>was</del> last saw the deceased alive on <u>6 Feb</u> 19 <u>66</u> , and that death occurred at <u>2:10 P.M.</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Paul H. Royse</u>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7 Feb 66</u>		
22c. PHYSICIAN'S NAME (Type) <u>PAUL H ROYSE</u>					22d. ADDRESS <u>1403 Foley La Pikesville 8 Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb 8, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Pikesville 8, Md.</u>		
24. FUNERAL DIRECTOR <u>Frank H. Newell, Pikesville 8, Md.</u>					25. REC'D BY REGISTRAR <u>Feb 11 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

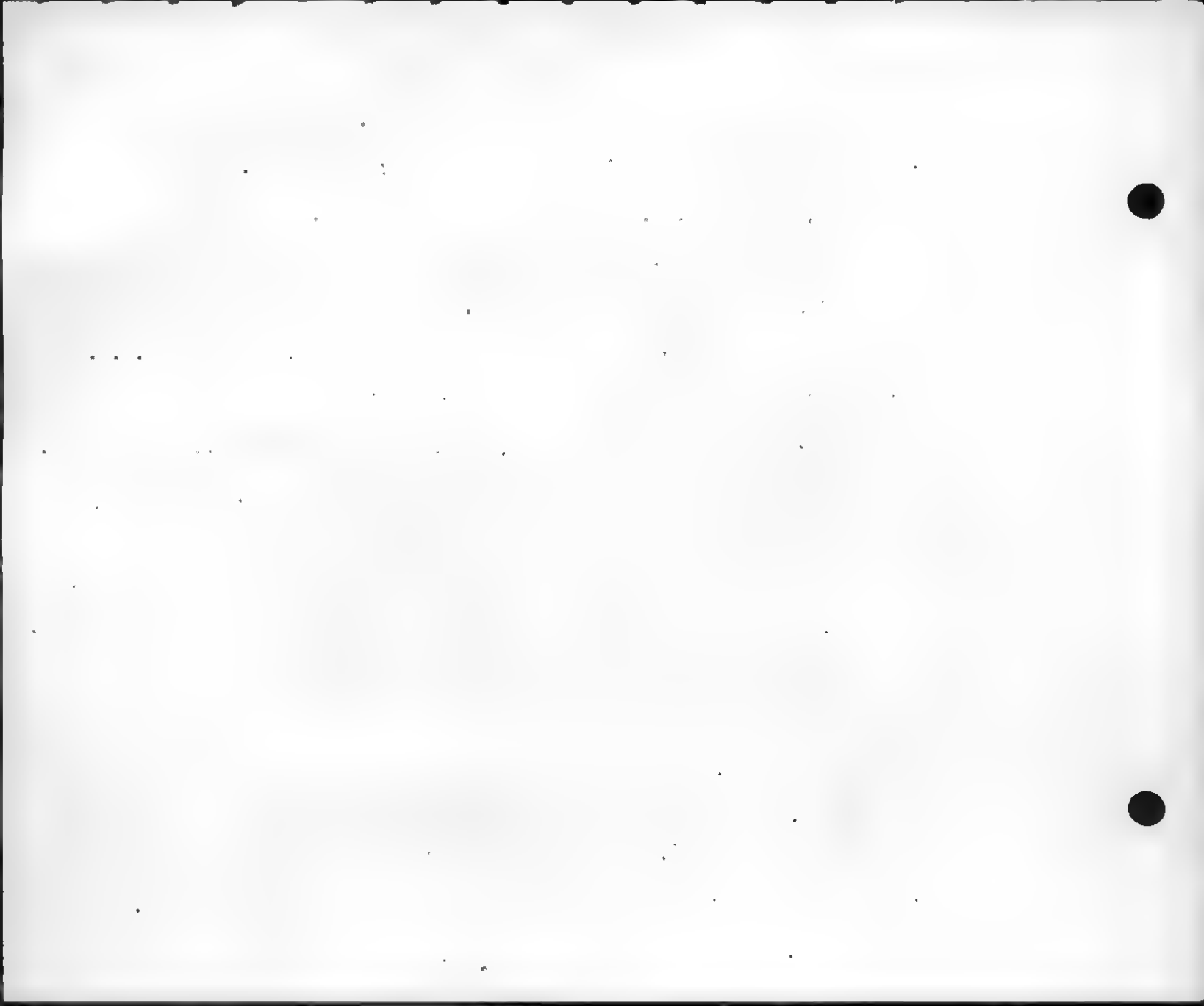


TO HOSPITAL OR ATTENDING PHYSICIAN: The death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
01952 Item 9-111-1-3/4 6/14/66 mh 01900											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Baltimore</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stevenson</u>				c. LENGTH OF STAY IN 1b <u>Lifetime</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stevenson, Md.</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Keller Avenue Stevenson, Md.</u>						d. STREET ADDRESS <u>Keller Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Ethel</u> Last <u>Keller</u>						4. DATE OF DEATH Month <u>February</u> Day <u>25</u> Year <u>1966</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 25, 1898</u>		9. AGE (in years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Pikesville, Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Louis Garrish</u>						14. MOTHER'S MAIDEN NAME <u>Ada Shipley</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>				16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT Address <u>Mr. Louis Keller, Keller Ave., Stevenson, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease - angina</u> <u>7:00</u> DUE TO (b) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1948</u> , 19 <u>  </u> to <u>present</u> , 19 <u>  </u> , that (I) (we) last saw the deceased alive on <u>18 Feb. 1966</u> , and that death occurred at <u>7 P</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Paul H Royse</u>						M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>26-FEB-1966</u>			
22c. PHYSICIAN'S NAME (Type) <u>PAUL H. ROYSE MD</u>						22d. ADDRESS <u>1403 FOLEY LANE PIKEVILLE MD</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>February 28, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Pikesville 8, Md.</u>	
24. FUNERAL DIRECTOR <u>Frank H. Newby, Pikesville 8, Md.</u>						ADDRESS		25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>FEB 28 1966</u>											



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

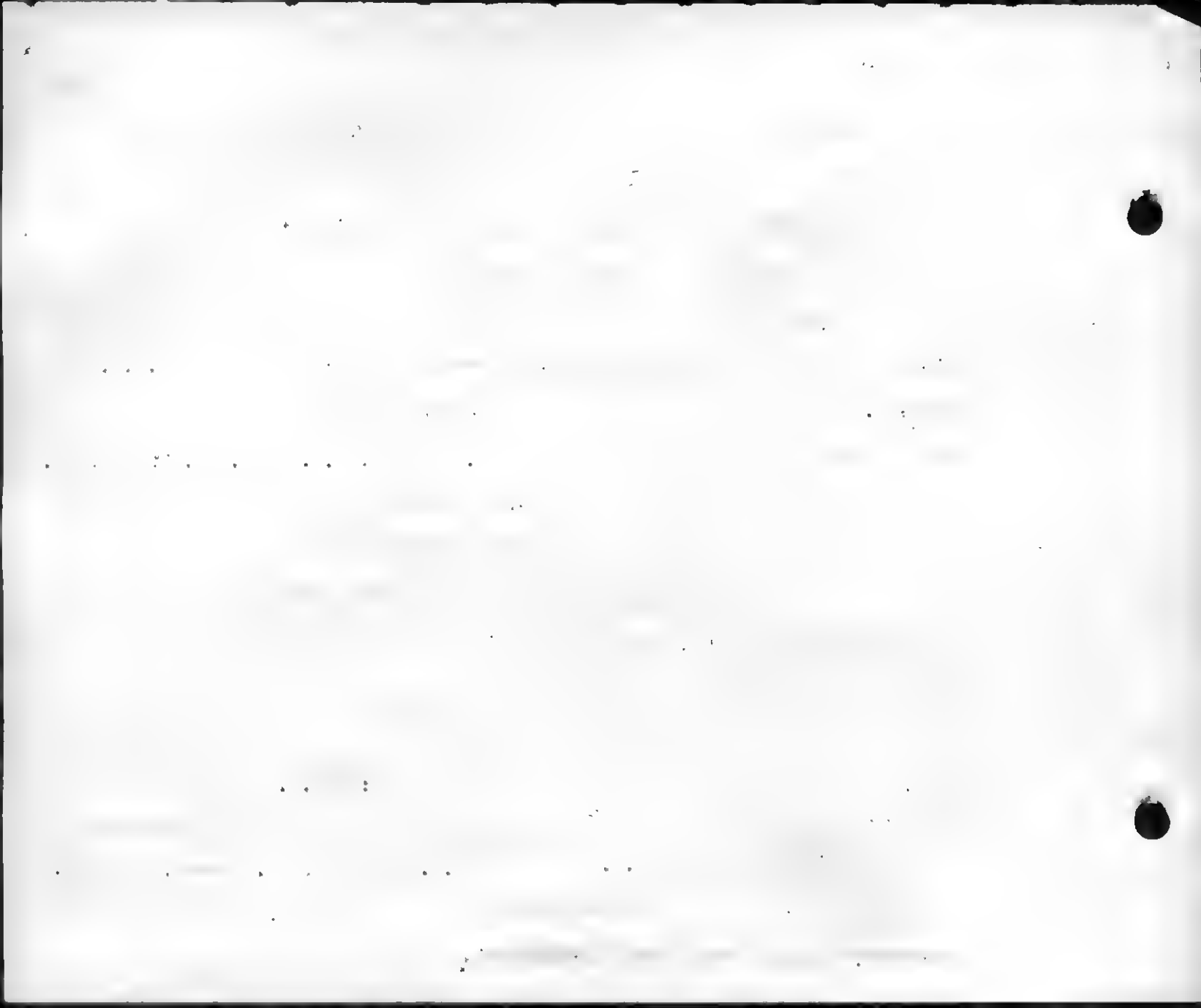
01953

01901

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Port Howard</b>				c. LENGTH OF STAY IN 1b <b>170 days</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>1912 Pulaski Street</b>			
3. NAME OF DECEASED (Type or print) First <b>Samuel</b> Middle <b>Lloyd</b> Last <b>Kent</b>				4. DATE OF DEATH Month <b>2</b> Day <b>17</b> Year <b>19 66</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6/8/89</b>	
9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (County & State, or foreign country) <b>Reedsville, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waiter</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Federal Service</b>		13. FATHER'S NAME <b>Thomas J. Kent</b>	
14. MOTHER'S MAIDEN NAME <b>Julia Ann Lucas</b>				15. WAS DECEASED EVER IN U.S. ARMY FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW I</b>			
16. SOCIAL SECURITY NO. <b>Unknown</b>				17. INFORMANT Address <b>Clin. Records, V.A. Hosp. Ft. Howard, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL VASCULAR ACCIDENT</b> 7-1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b> (c) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b>							INTERVAL BETWEEN ONSET AND DEATH MINUTES  YEARS  YEARS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>OLD THROMBOSIS OF LEFT MIDDLE CEREBRAL ARTERY</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>8/30</b> , 19 <b>65</b> , to <b>2/17</b> , 19 <b>66</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>2/17</b> , 19 <b>66</b> , and that death occurred at <b>9:45 PM</b> on the causes and on the date stated above.							
22a. SIGNATURE <i>Paulino Deocampo, M.D.</i>				22b. DATE SIGNED <b>2/19/66</b>		22c. PHYSICIAN'S NAME (Type) <b>PAULINO DEOCAMPO, M.D.</b>	
22d. ADDRESS <b>V.A. Hospital, Ft. Howard, Maryland</b>				23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>			
23b. DATE THEREOF <b>2/23/66</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Shiloh Baptist</b>		23d. LOCATION (City, town or county) (State) <b>Lilian, Virginia</b>	
24. FUNERAL DIRECTOR <b>George G. Kelson - 1348 N. Calhoun St.</b>				25a. REC'D BY REGISTRAR <b>FEB 23 1966</b>		25b. REGISTRAR'S SIGNATURE <i>J. Lewis Judge</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and at any event, within 72 hours after death.

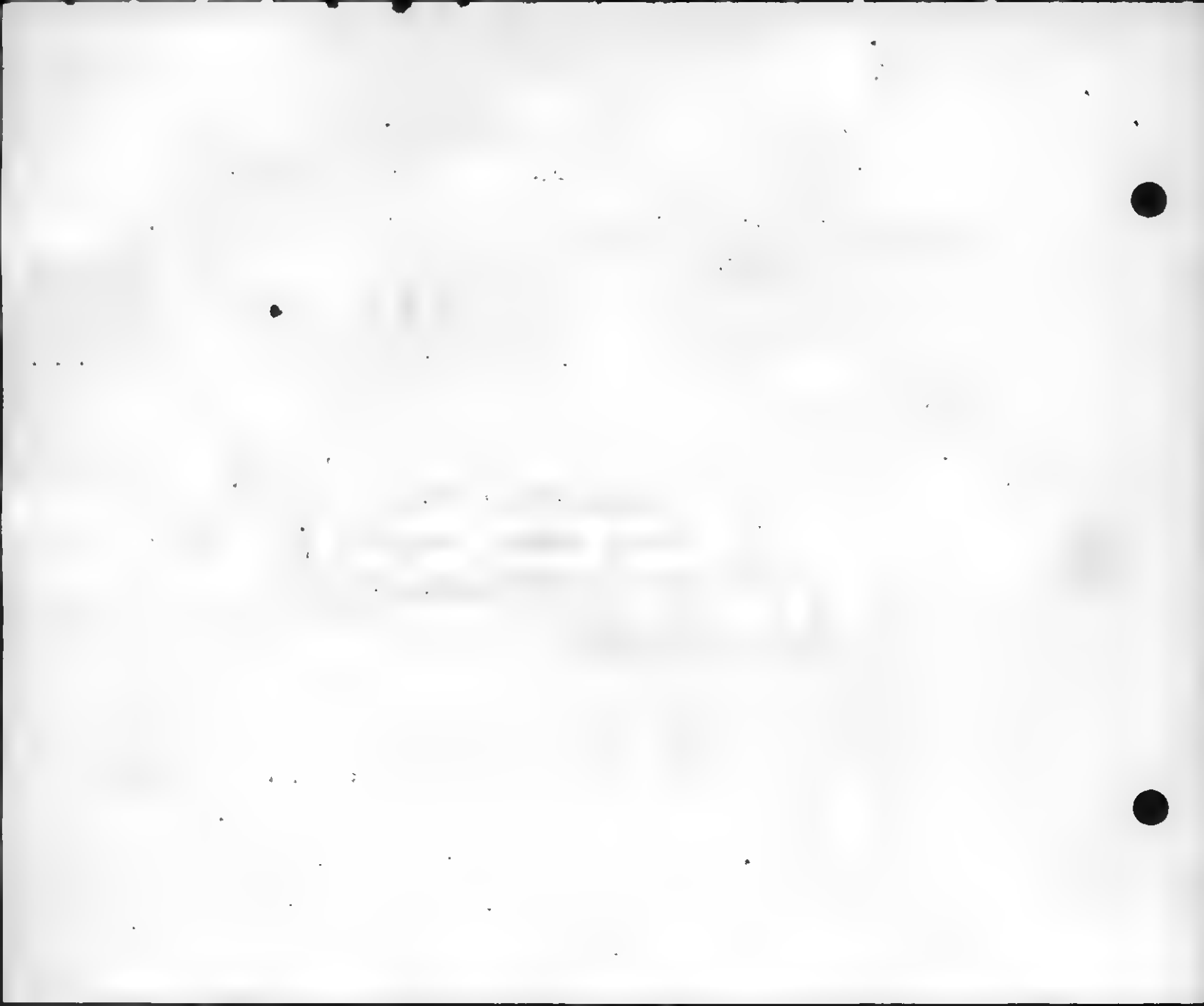


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>		c. LENGTH OF STAY IN 1b <b>15 1/2 yrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Rosewood State Hospital</b>		d. STREET ADDRESS <b>3433 Park Heights Ave.</b>	
3. NAME OF DECEASED (Type or print) <b>Marjorie</b>		4. DATE OF DEATH <b>2</b> <b>4</b> <b>19 66</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/20/34</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dependent</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Harry Kerber</b>		14. MOTHER'S MAIDEN NAME <b>Bessie Roll</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>25-10-8780</b>	
17. INFORMANT <b>Rosewood Records, Owings Mills, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia, both</b> <b>491X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>lower lobes, aspiration type</b> (c) <b>Spastic Quadriplegia</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Mental Retardation</b>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>19</b>		20d. INJURY OCCURRED <b>While at work</b> <input type="checkbox"/> <b>Not While at work</b> <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (s) (this hospital) attended the deceased from <b>3-17</b> , 19 <b>50</b> , to <b>2-4</b> , 19 <b>66</b> , that (if (we) last saw the deceased alive on <b>2-4</b> , 19 <b>66</b> , and that death occurred at <b>10:00</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Harry G. Butler</b>		22b. DATE SIGNED <b>4 Feb 66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Harry G. Butler</b>		22d. ADDRESS <b>Rosewood State Hospital</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/6/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Delmar Young Men</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR <b>Sol Levinson &amp; Bros Inc 6600 Reisterstown Rd</b>		25a. REC'D BY REGISTRAR <b>Feb 7 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

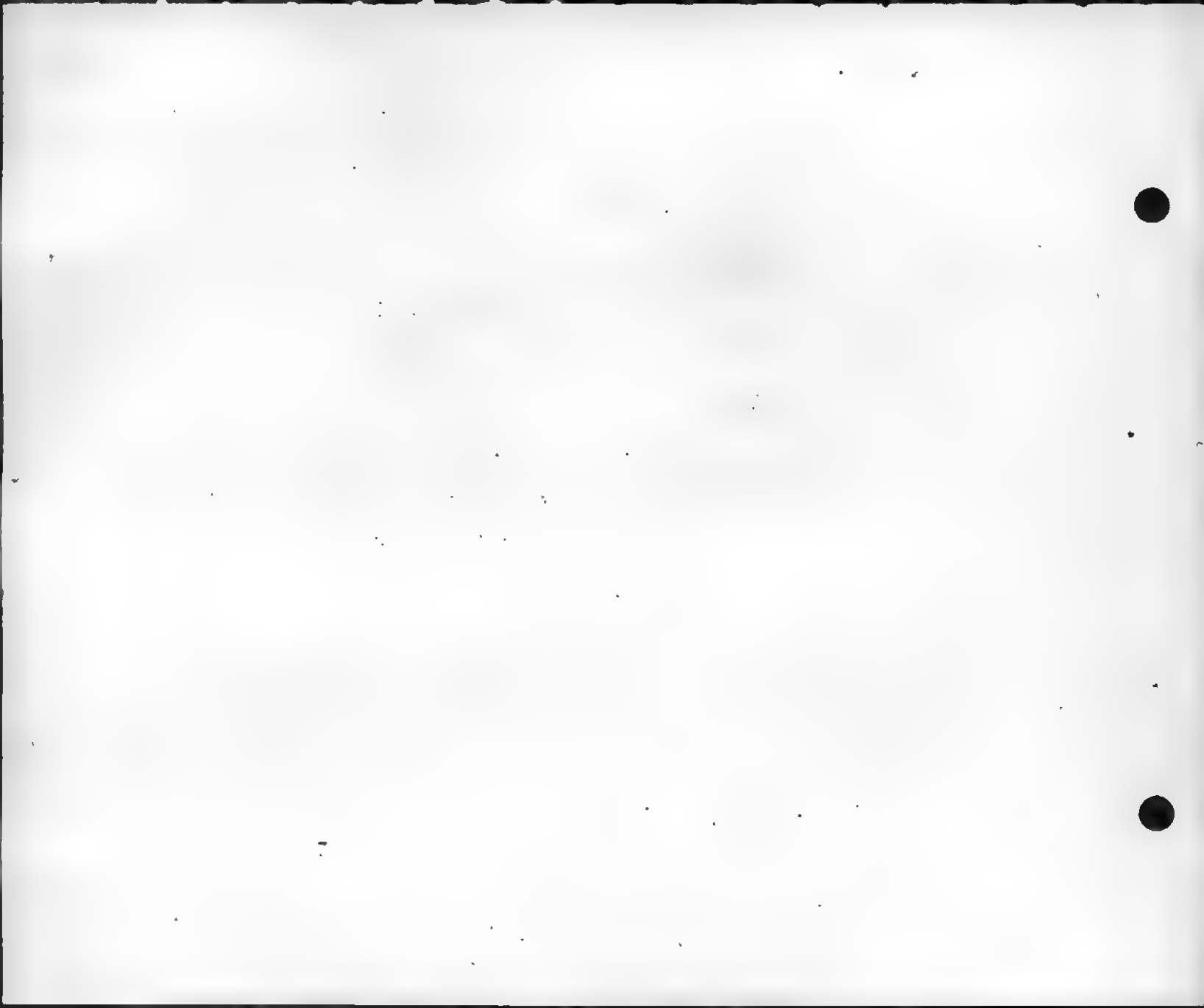
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> <u>1200</u> DUE TO (b) <u>Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) <u>APHD &amp; Cerebral</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6-29</u> , 19 <u>66</u> , to <u>2-14</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2-8</u> , 19 <u>66</u> , and that death occurred at <u>4 A</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Manuel J. Rodriguez</u> M.D.		22b. DATE SIGNED <u>2-14-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>MANUEL J. RODRIGUEZ</u>		22d. ADDRESS <u>736 NOTTINGHAM RD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/16/1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR <u>Wm. F. Zikner &amp; Sons</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
25c. ADDRESS <u>Baltimore, Md.</u>		DATE <u>FEB 15 1966</u>	

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>329 Harlem Lane</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> d. STREET ADDRESS <u>329 Harlem Lane</u> 28 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) <u>Nanny Elizabeth KIDD</u>		4. DATE OF DEATH Month <u>2</u> Day <u>14</u> Year <u>1966</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 29, 1875</u>		9. AGE (in years last birthday) <u>90</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NURSE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>NURSING HOME</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Kidd</u>				14. MOTHER'S MAIDEN NAME				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>212-07-9148</u>				17. INFORMANT <u>Mrs. Frances Kelley</u> Address <u>920 Kent Avenue</u>			

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
01955. CERTIFICATE OF DEATH 01903



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

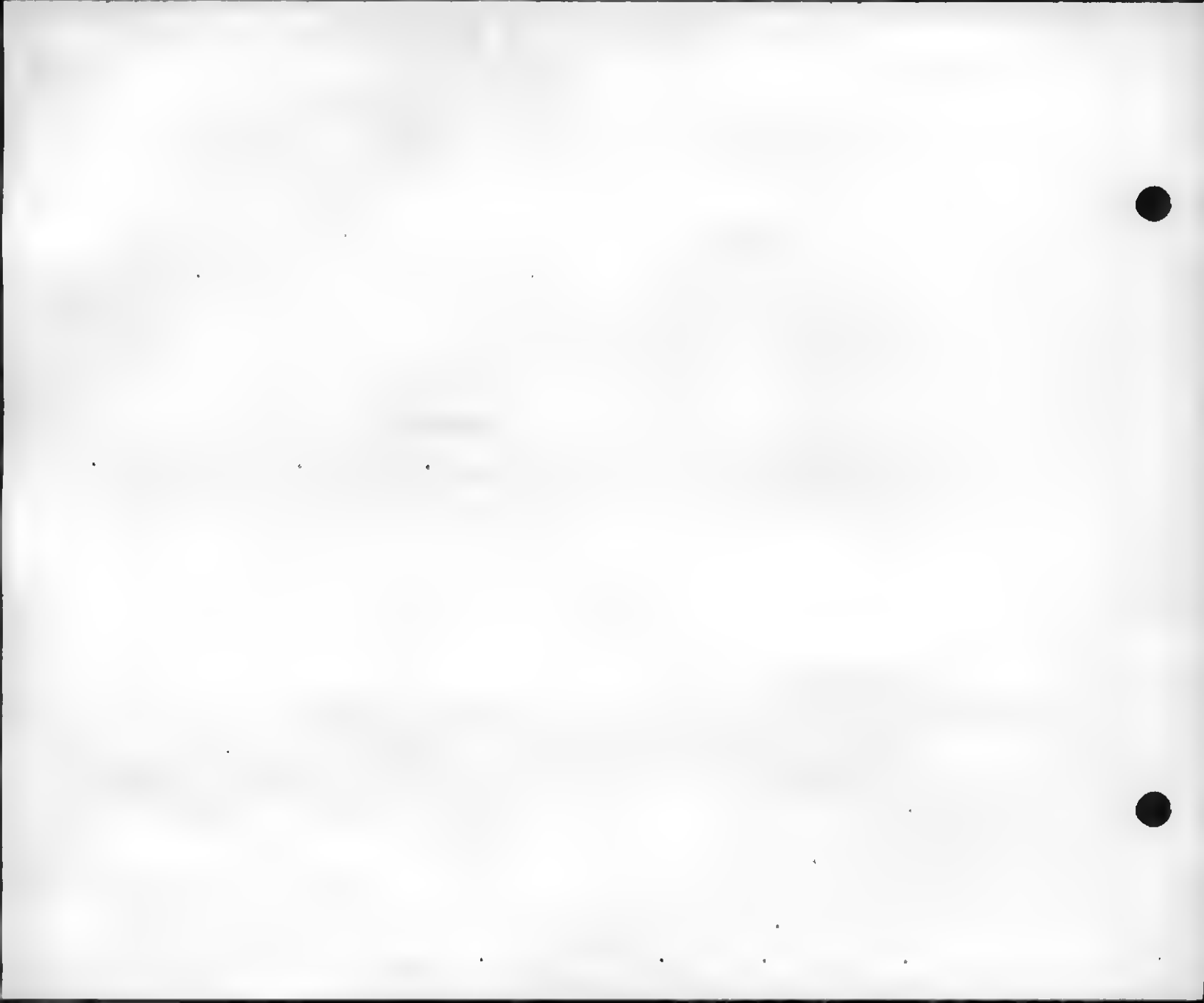
01904

01956

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>381 E 21</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>-</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1456 Galena Road</u>		d. STREET ADDRESS <u>1456 Galena Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Edna</u> Middle <u>Catherine</u> Last <u>King</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>28</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 1, 1907</u>
9. AGE (In years last birthday) <u>58</u> yrs		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	11. IF UNDER 24 HRS Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>	
11. BIRTHPLACE (County & State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Stein</u>		14. MOTHER'S MAIDEN NAME <u>Amelia Stonath</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>213-10-8861</u>	
17. INFORMANT <u>Henry J. King, Sr.</u>		Address <u>1456 Galena Rd.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchogenic Carcinoma</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>  </u>
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>  </u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	20f. (City or town) (County) (State) <u>  </u>
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 20, 1965</u> to <u>Feb 28, 1966</u> , that (I) (we) last saw the deceased alive on <u>Feb. 15, 1966</u> , and that death occurred at <u>11:4</u> A.M. from causes and on the date stated above.			
22a. SIGNATURE <u>Manuel P. de Leon</u>		22b. DATE SIGNED <u>  </u>	
22c. PHYSICIAN'S NAME (Type) <u>MANUEL P. DE LEON M.D.</u>		22d. ADDRESS <u>7840 Eastern Ave - Bk 20, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Mar. 3, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>	23d. LOCATION (City or town) (County) (State) <u>Baltimore, Maryland</u>
24. FUNERAL DIRECTOR <u>John A. Moran, Inc. 3000 E. Baltimore St.</u>		25a. REC'D BY REGISTRAR <u>MAR 2 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. REGISTRAR'S NAME <u>  </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the other papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 11/59

1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

01905

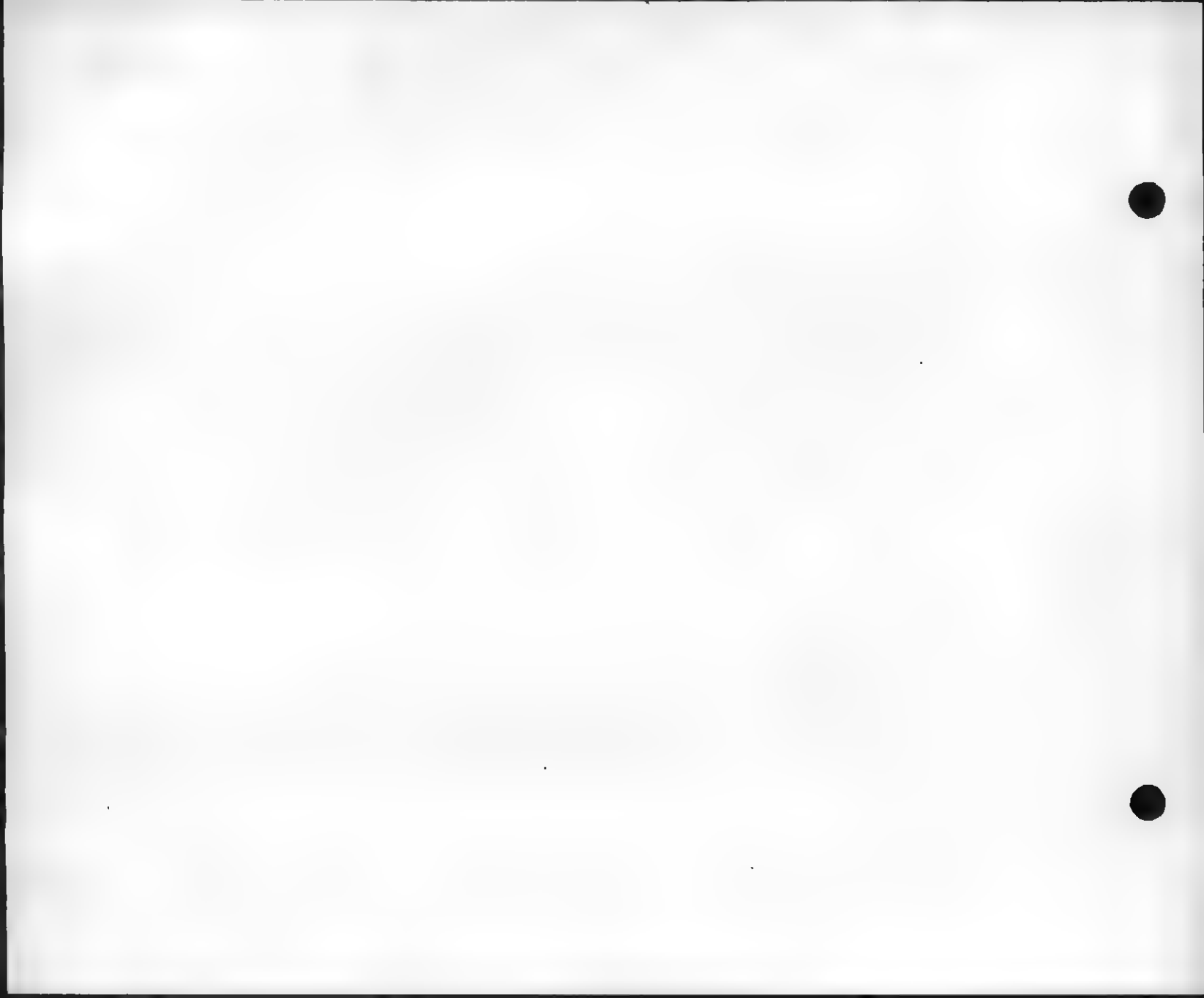
01957

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arco Acres (20)</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>12 Hydroplane Drive</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>ISABELLA ANNA KING</b>				4. DATE OF DEATH Month Day Year <b>February 17, 1966</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 28, 1896</b>	
9. AGE (In years last birthday) yrs <b>69</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		11. BIRTHPLACE (State or foreign country) <b>Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Adam Parr</b>				14. MOTHER'S MAIDEN NAME <b>Anna Krichner</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>136 26 9143</b>		17. INFORMANT <b>David J. King</b>		Address <b>Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer of Uterus -</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1, 1966</b> to <b>Feb 17, 1966</b> ; that (I) (we) last saw the deceased alive on <b>Feb 15, 1966</b> , and that death occurred at <b>11 PM</b> , from the causes and on the date stated above							
22a. SIGNATURE <b>Irving Beck</b>				22b. DATE SIGNED <b>February 18, 1966</b>			
22c. PHYSICIAN'S NAME (Type) <b>Irving Beck, M.D.</b>				22d. ADDRESS <b>901 Fuselage Ave. Balto., Md. 21220</b>			
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/21/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore County, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Daniel J. Bruzdinski</b>				25a. REC'D BY REGISTRAR <b>FEB 21 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
01958					01906				
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mount Wilson</b>			c. LENGTH OF STAY IN 1b <b>7 weeks</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>			d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Mount Wilson State Hospital</b>					d. STREET ADDRESS <b>205 DETROIT AVENUE</b>				
3. NAME OF DECEASED (Type or print) First <b>LULA</b> Middle <b>JANE</b> Last <b>KIRK</b>					4. DATE OF DEATH Month <b>2</b> Day <b>3</b> Year <b>1966</b>				
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-15-94</b>		9. AGE (In years last birthday) <b>71</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DOMESTIC</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>DOMESTIC SERV.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>TENNESSEE</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>JAMES NEWTON</b>					14. MOTHER'S MAIDEN NAME <b>PARALEE BASKIN</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT Address <b>Hosp. records, Mt. Wilson St. Hospital</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHIO - PNEUMONIA</b> <b>441A</b> DUE TO (b) <b>FRACTURE OF NECK OF FEMUR</b> DUE TO (c) <b>12 weeks</b>									INTERVAL BETWEEN ONSET AND DEATH <b>8 weeks</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>PULMONARY TUBERCULOSIS</b>									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>12/13, 1965</b> , to <b>2/3, 1966</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>2/3, 1966</b> , and that death occurred at <b>4:00 P.M.</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>Wm. Newcomer</b>					22b. DATE SIGNED <b>2/3/66</b>			22c. PHYSICIAN'S NAME (Type) <b>Wm. Newcomer, M.D., Superintendent</b>	
22d. ADDRESS <b>Mount Wilson, Maryland</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>2/7/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadow Ridge</b>		23d. LOCATION (City, town or county) (State) <b>Elkridge, Md.</b>		
24. FUNERAL DIRECTOR <b>Ullrich Funeral Home Dundalk, Md.</b>					25a. REC'D BY REGISTRAR <b>Feb 10 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		



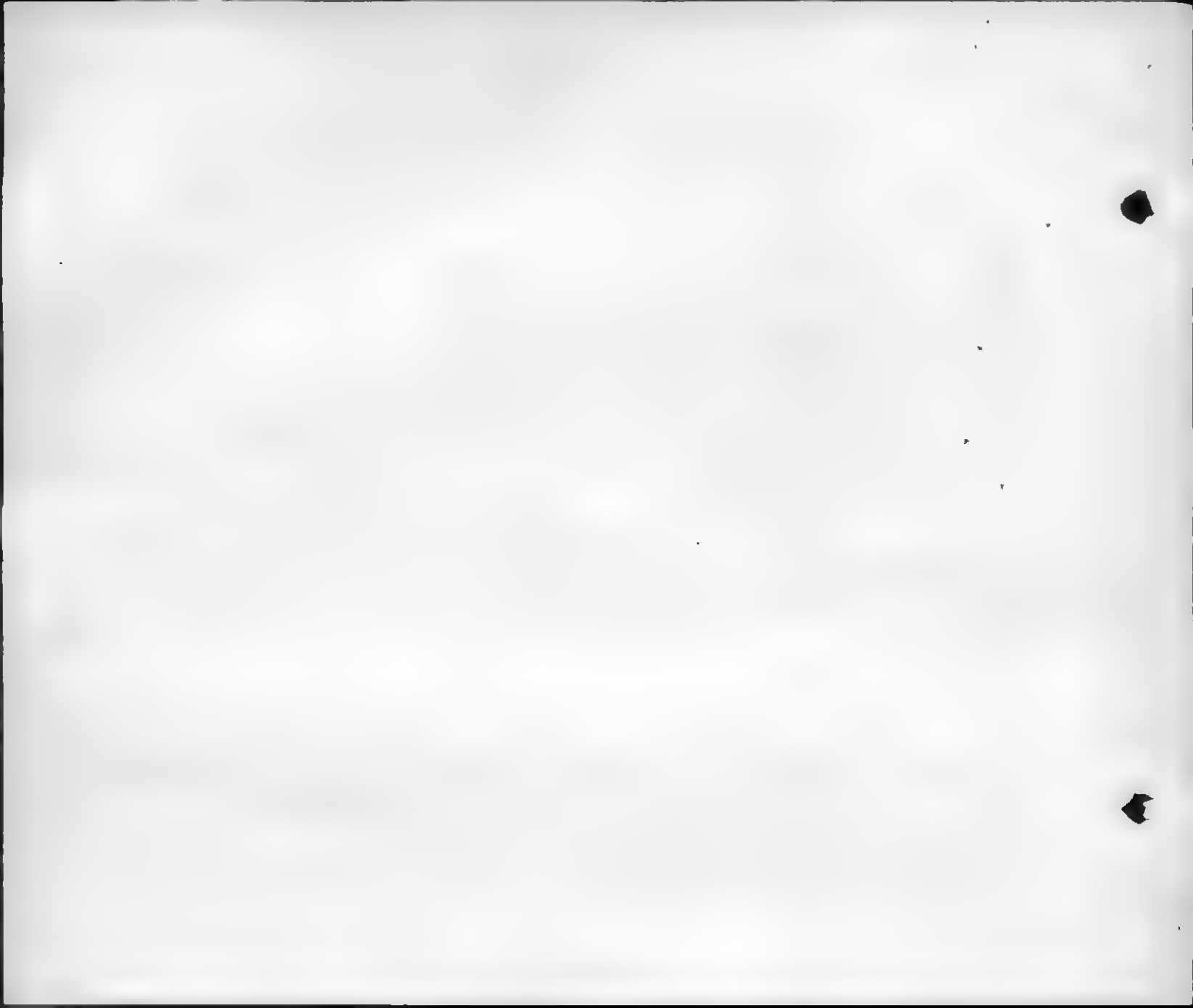
# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 01907

1 PLACE OF DEATH a. COUNTY <u>Balto</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eatonville</u>		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>MD</u> b. COUNTY	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eatonville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House in Pines - Rusting Ave</u>		d. STREET ADDRESS <u>5703 Johnnyoaks Rd</u>	
3 NAME OF DECEASED (Type or print) <u>Benjamin J</u> First <u>Kline</u> Middle Last		4 DATE OF DEATH <u>February 1</u> 1966 Month Day Year	
5 SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 6/80</u> 9. AGE (In years last birthday) <u>85</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>American</u>	
11 BIRTHPLACE (State or foreign country) <u>Virginia</u>		12 CITIZEN OF WHAT COUNTRY? <u>W S A</u>	
13. FATHER'S NAME <u>James Kline</u>		14. MOTHER'S MAIDEN NAME <u>Eva</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16 SOCIAL SECURITY NO. <u>216-09-2896</u>	
17 INFORMANT <u>Mrs. Wilson</u> Address <u>Willingham</u>		18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1221</u> DUE TO <u>Myocardial Degeneration</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardio-Vascular Disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u> <u>1537</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-31-1964</u> to <u>2-1-1966</u> , that I last saw the deceased alive on <u>1-31-1966</u> , and that death occurred at <u>8 A. M.</u> from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>6209 Frederick Ave.</u> DATE SIGNED			
ACTUAL SIGNATURE <u>Wilmer K. Gallagher</u> M.D.		PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallagher</u> <u>Eatonville, 28 Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Feb. 4/66</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge</u>	22d. LOCATION (City, town, or county) (State) <u>Maryland</u>
23 FUNERAL DIRECTOR'S SIGNATURE <u>Little Hill 4101 Edmonson</u> ADDRESS <u>aw</u>		24 REC'D BY REGISTRAR <u>aw</u> DATE <u>FEB 4 1966</u>	24b REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1  
FOR STATE  
HEALTH DEPT  
M

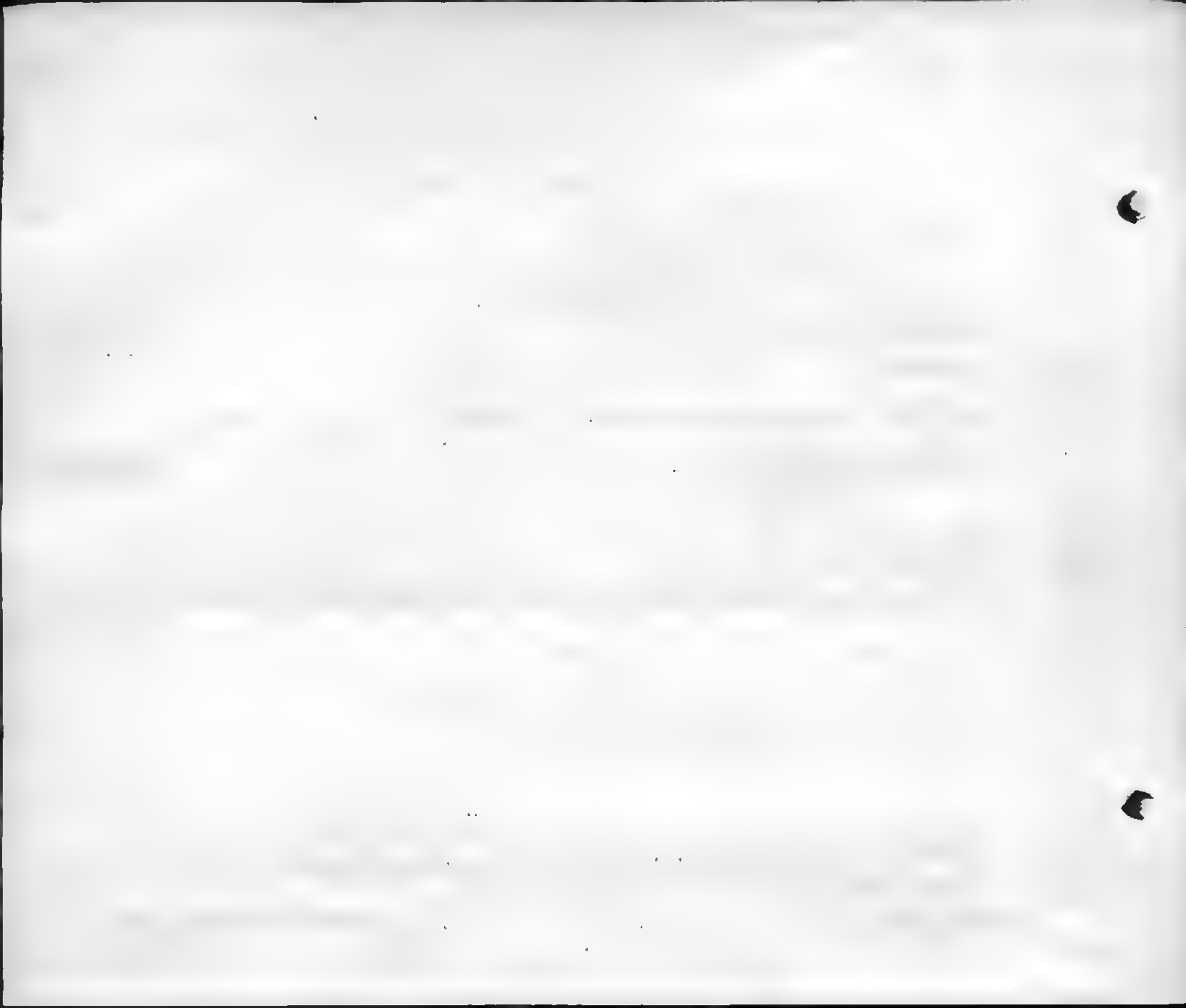
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01960

01908

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>		c. LENGTH OF STAY IN 1b <b>MARYLAND</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>7400 German Hill Road</b>		e. STREET ADDRESS <b>7400 German Hill Road</b>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Herman Ernest Koch</b>		4. DATE OF DEATH Month <b>February</b> Day <b>12</b> Year <b>1966</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 4, 1895</b>	9. AGE (in years last birthday) <b>70</b> yrs.	10. IF UNDER 1 YEAR Months <b>70</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Florist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Flowers</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Hugo Koch</b>		14. MOTHER'S MAIDEN NAME <b>Matilda ?</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT <b>Herman J. Koch 7400 German Hill Road</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>A-S-C-V Disease</b> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Due to</b> (c) <b>Due to</b>		INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>M.B. Davis</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>M.B. Davis, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
		Address (Street, city, town, or county) <b>6800 Morningside Road</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/16/66</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR <b>Ullrich Funeral Home Dundalk, Md.</b>		24a. REC'D BY REGISTRAR <b>FEB 21 1966</b>		24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15 (4)  
20M 1/65

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>									
<b>01961</b> 1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b> c. LENGTH OF STAY IN 1b <b>11 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>					<b>01909</b> 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence Before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> d. STREET ADDRESS <b>2879 MAYFIELD AVENUE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>EDWARD</b> Middle <b>CHARLES</b> Last <b>KOENEKE</b>					4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>19</b> Year <b>1966</b>				
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MAY 22, 1889</b>		9. AGE (in years last birthday) <b>76</b> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SPRINKLER FITTER</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CHARLES KOENEKE</b>					14. MOTHER'S MAIDEN NAME <b>FREDA</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>WW-1</b>		17. INFORMANT <b>CLIN. REC., VAH, FT. HOWARD, MARYLAND</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RIGHT MIDDLE CEREBRAL ARTERY THROMBOSIS</b> <b>3024</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DUE TO</b> (c) <b>DUE TO</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									INTERVAL BETWEEN ONSET AND DEATH <b>4 Weeks</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (X) (this hospital) attended the deceased from <b>Feb. 8 3:30 19 66</b> to <b>Feb. 19 19 66</b> , that (X) (we) last saw the deceased alive on <b>Feb. 19 19 66</b> , and that death occurred at <b>a. M.</b> from the causes and on the date stated above.									
22a. SIGNATURE <i>[Signature]</i>					22b. DATE SIGNED <b>2-19-66</b>				
22c. PHYSICIAN'S NAME (Type) <b>LOUIS E. KIMMEL, M.D.</b>					22d. ADDRESS <b>VAH, FORT HOWARD, MARYLAND</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>Feb. 22, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL</b>		23d. LOCATION (City, town or county) (State) <b>BROOKLYN, MARYLAND</b>			
24. FUNERAL DIRECTOR <b>McCULLY FUNERAL HOME</b> <b>130 E. FORT AVENUE</b> <b>BALTIMORE, MD.</b>					25a. REC'D BY REGISTRAR <b>FEB 23 1966</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 01910

01962

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE-22</u>		c. LENGTH OF STAY IN 1b <u>1 WEEK</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4100 Eder Road</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE-19-</u>	
		d. STREET ADDRESS <u>7311 Geis Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>W.</u> Last <u>KRAEMER</u>		4. DATE OF DEATH Month <u>February</u> Day <u>2</u> Year <u>66</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 19, 1895</u>
9. AGE (In years last birthday) yrs <u>70</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bethlehem Steel</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Kraemer</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Jones</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Ferdinand J. Kraemer</u>	
17. INFORMANT <u>Ferdinand J. Kraemer</u>		Address <u>4100 Eder Road</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARCINOMA. LIVER.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>                    </u> DUE TO (c) <u>                    </u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 Mo</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>                    </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>9/24</u> 19 <u>57</u> to <u>2/2</u> 19 <u>66</u> , that I last saw the deceased alive on <u>Jan. 16, 1966</u> , and that death occurred at <u>6:50 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Louis N. Tollin</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>6908 N. B+ Rd. Feb. 2/66</u>	
PHYSICIAN'S NAME (Type) <u>LOUIS N. TOLLIN</u>		<u>BALTO. MD. 21219</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-5-1966</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore County, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lilly &amp; Zeiler Inc.</u>		ADDRESS <u>1901 Eastern Ave.</u>	
24a. REC'D BY REGISTRAR <u>DATE</u>		24b. REGISTRAR'S SIGNATURE <u>                    </u>	

TO HOSPITAL OR TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

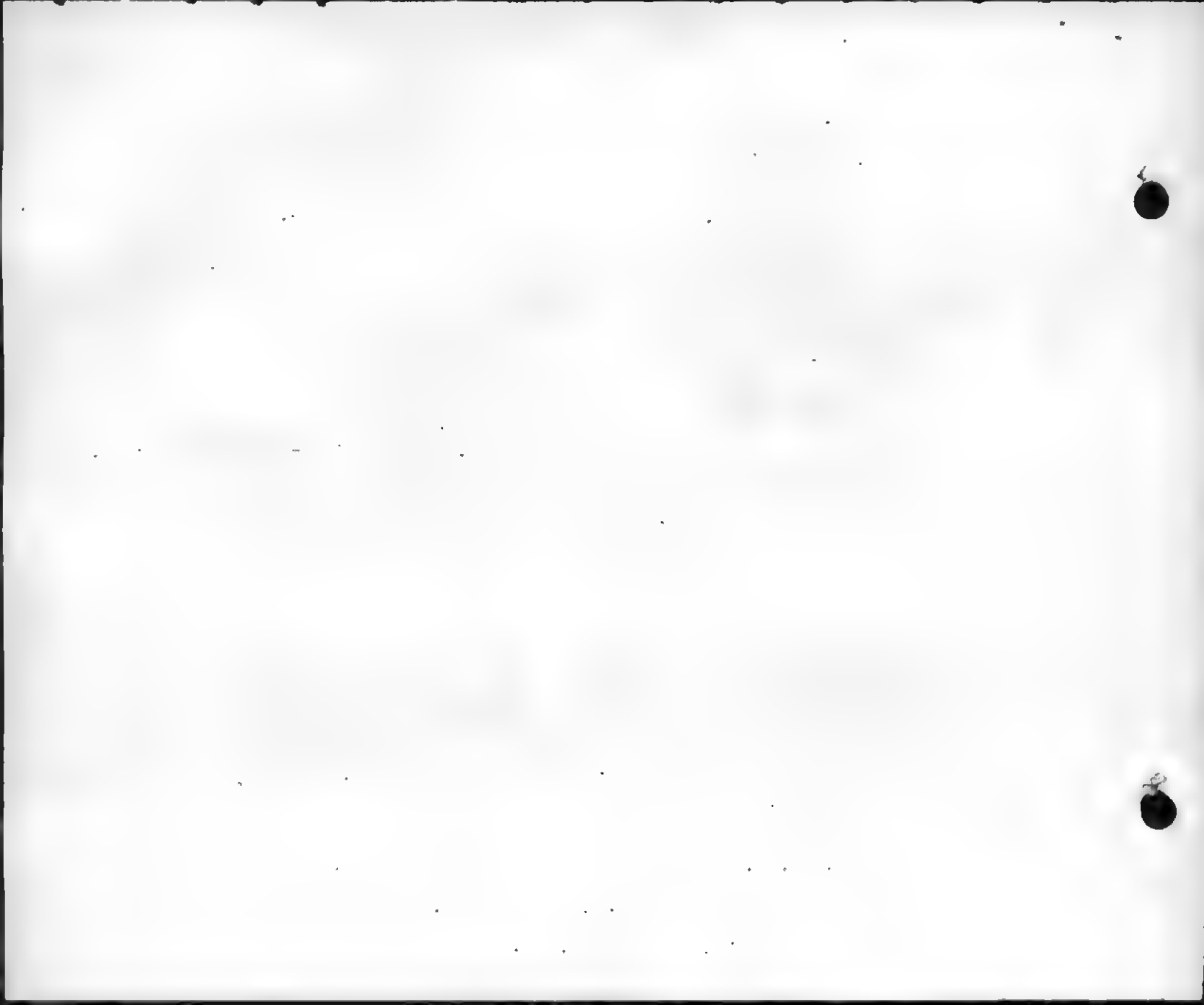


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01963 CERTIFICATE OF DEATH 01911											
1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>7408 Digby Rd.</b>						d. STREET ADDRESS <b>7408 Digby Rd.</b>					
3. NAME OF DECEASED (Type or print) First <b>SADIE</b> Middle <b>KRAMER</b> Last						4. DATE OF DEATH Month <b>Feb</b> Day <b>22</b> Year <b>1966</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) <b>72</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Oays Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Rumania</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Lazer Stoop</b>						14. MOTHER'S MAIDEN NAME <b>Unknown</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFIRMANT <b>Mrs. Hilda Silver-3503 Maryvale Rd.</b>				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thromboses</b> DUE TO (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>Diabetes - Hypertension</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>July</b> , 19 <b>65</b> to <b>Feb 12</b> , 19 <b>66</b> that (I) (we) last saw the deceased alive on <b>2-22</b> , 19 <b>66</b> , and that death occurred at <b>3 A.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Dr. R. Pere Mera</b>						M.D. ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. R. Pere Mera</b>						22d. ADDRESS <b>7306 Liberty Rd.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>2/23/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Shaarei Zion Cong.</b>				23d. LOCATION (City, town or county) (State) <b>Baltimore, Maryland</b>			
24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS INC. 6010 Reist. Rd.</b>						25a. REC'D BY REGISTRAR <b>FEB 24 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01964

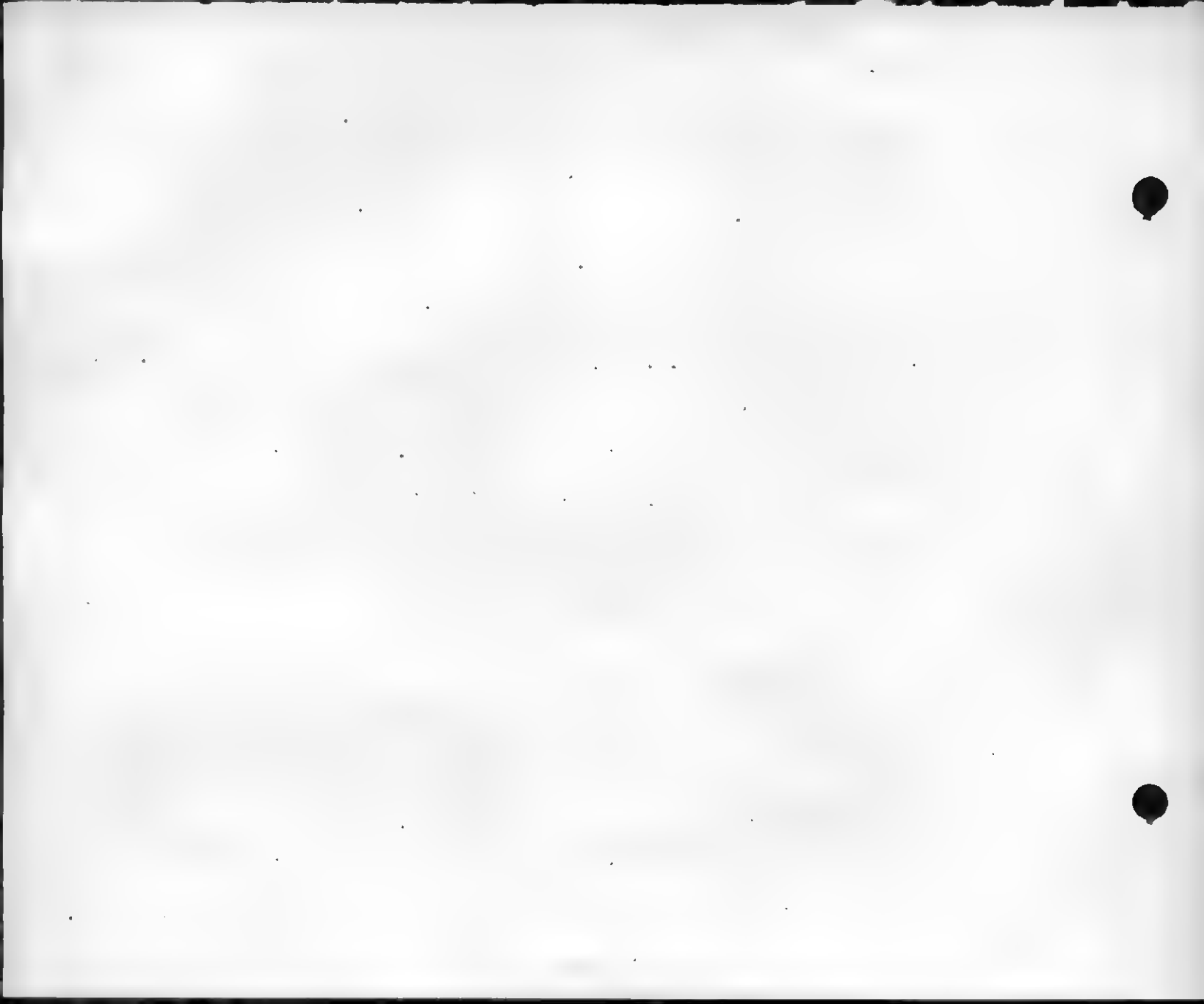
# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

01012

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Overlea</b> c. LENGTH OF STAY IN 1b <b>25yrs</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>3 Manor Ave. #6</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Overlea Rural</b> d. STREET ADDRESS <b>3 Manor Road #6</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ellwood</b> Middle <b>M.</b> Last <b>Kranz</b>		4. DATE OF DEATH Month <b>2</b> Day <b>28</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-10-1891</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Voucher Examiner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Army</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>
13. FATHER'S NAME <b>George A. Kranz</b>		14. MOTHER'S MAIDEN NAME <b>Halett Martin</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>218-22-0138</b>	
17. INFORMANT <b>Mrs Anna P. Kranz</b>		Address <b>3 Manor Road Baltimore</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Atherosclerotic Cardiovascular Disease</b> <b>45yr</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Extensive Myocardial Infarction in past 3 yrs</b> DUE TO (c) <b>and Congestive failure</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Several yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1964</b> , 19 to <b>2-28</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>2-27-66</b> , and that death occurred at <b>6A</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>John C. Hyle</b>		22b. DATE SIGNED <b>2-28-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN C. Hyle</b>		22d. ADDRESS <b>7527 Belair Rd Baltimore Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>3-2-1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Baltimore, Co. Md.</b>
24. FUNERAL DIRECTOR <b>Lassman Funeral Home</b>		25a. REC'D BY REGISTRAR <b>MAR 2 1966</b>	
ADDRESS <b>7401 Belair Road</b>		25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The form requires that the certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
01965					CERTIFICATE OF DEATH					01913				
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 12</u>					c. LENGTH OF STAY IN 1b <u>Baltimore 12</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 12</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Armacost Nursing Home</u>					d. STREET ADDRESS <u>304 Overbrook Road</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last <u>K. Marguerite Krause</u>					4. DATE OF DEATH Month Day Year <u>Feb. 19 1966</u>									
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 3, 1895</u>		9. AGE (In years last birthday) <u>70 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary-Retired</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>Balto. Welfare Brd.</u>					11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>				
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					13. FATHER'S NAME <u>John Jacob Krause</u>					14. MOTHER'S MAIDEN NAME <u>Katie E. Unklebach</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>					16. SOCIAL SECURITY NO. <u>212-32-4839</u>					17. INFORMANT Address <u>Mrs. Mable E. Krause (Same)</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF LUNG</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) _____ DUE TO (c) _____										INTERVAL BETWEEN ONSET AND DEATH <u>1-2-66</u>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Tumor</u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>Yes</u>										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>					20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				
20f. (City or town) (County) (State)														
21. I certify that (I) (this hospital) attended the deceased from <u>July 11, 1961</u> to <u>Feb 19, 1966</u> that (I) (we) last saw the deceased alive on <u>Feb 15, 1966</u> and that death occurred at <u>10:30 PM</u> , from the causes and on the date stated above.														
22a. SIGNATURE <u>A. S. Chalfant</u>										22b. DATE SIGNED <u>Feb 21, 66</u>				
22c. PHYSICIAN'S NAME (Type) <u>A. S. Chalfant</u>										22d. ADDRESS <u>6210 York Road</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					23b. DATE THEREOF <u>2/22/1966</u>					23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore</u>				
23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>														
24. FUNERAL DIRECTOR <u>H.W. Jenkins &amp; Sons Co.</u>					ADDRESS <u>4905 York Road Balto. 12, Md.</u>					25a. REC'D BY REGISTRAR DATE <u>FEB 23 1966</u>				
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>														



VR A15 (4)  
20M 5.63

## 01966

01914

<b>1. PLACE OF DEATH</b> a. COUNTY <u>BALTIMORE</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OWING MILLS</u> c. LENGTH OF STAY IN TB <u>15 mo</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>ROSEWOOD STATE HOSPITAL</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if Institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u> d. STREET ADDRESS <u>5609 CHILLUM HEIGHTS</u>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>RICHARD PHILLIP LABARCENA</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>4. DATE OF DEATH</b> Month Day Year <u>2 13 1966</u>	
<b>5. SEX</b> <u>M</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>2-12-64</u>	<b>9. AGE</b> (In years last birthday) <u>2</u> yrs. <b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>NONE</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>WASHINGTON, D.C.</u>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>WASHINGTON, D.C.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>FERMIN LABARCENA</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>MARIA TORRES</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b> <u>NONE</u>	
<b>17. INFORMANT</b> <u>ROSEWOOD STATE HOSPITAL</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONIA</u> <u>473X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>MENTAL RETARDATION - EPILEPSY</u>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State)
<b>21. I certify that</b> <u>X</u> (this hospital) attended the deceased from <u>11-18</u> , 19 <u>65</u> , to <u>2-13</u> , 19 <u>66</u> , that <u>X</u> (we) last saw the deceased alive on <u>2-13</u> , 19 <u>66</u> , and that death occurred at <u>1 A.M.</u> from the causes and on the date stated above			
<b>22a. SIGNATURE</b> <u>Harry G. Butler</u>		<b>22b. DATE SIGNED</b> <u>2-14-66</u>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Harry G. Butler, M.D.</u>		<b>22d. ADDRESS</b> <u>Rosewood Lane, Owings Mills, Md.</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>2-15-66</u>		<b>23b. DATE THEREOF</b> <u>2-15-66</u>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>WANT, D. of Md. U. of Md. BALTIMORE, Md.</u>		<b>23d. LOCATION</b> (City, town or county) (State)	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Frank H. Russell</u>		<b>25a. REC'D BY REGISTRAR</b> <u>FEB 16 1966</u>	
<b>25b. REGISTRAR'S SIGNATURE</b>		<b>25c. REGISTRAR'S SIGNATURE</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

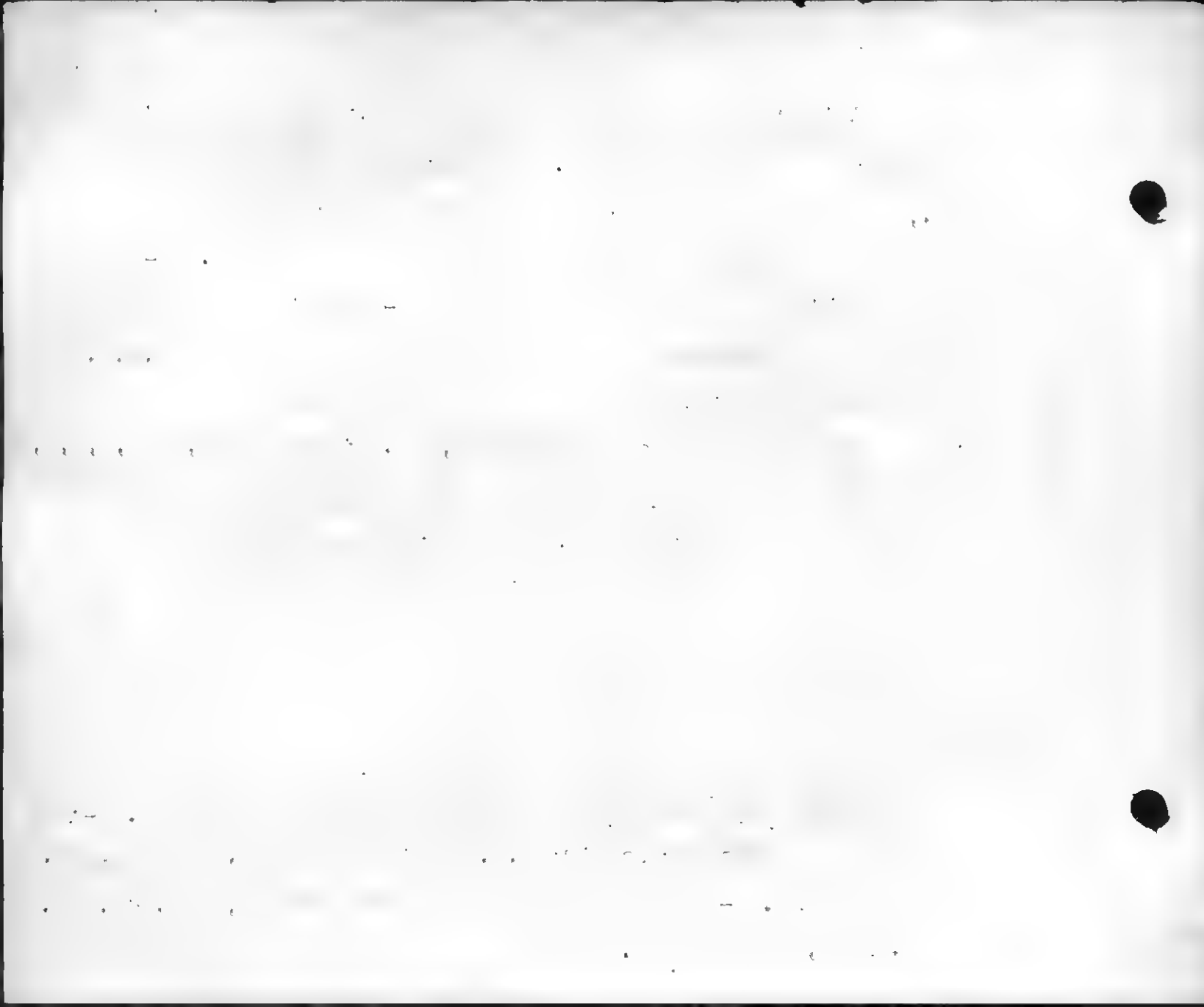
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

01967

01915

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b> c. LENGTH OF STAY IN 1b <b>18 yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Res., 6917 Holabird Avenue</b>				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Dundalk 21222</b> d. STREET ADDRESS <b>6917 Holabird Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>KATHARYN LAKE</b>			4. DATE OF DEATH <b>Feb. 5 19 66</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <b>June 19-1898</b>		9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR: Months <b>5</b> Days <b>19</b> Hours <b>66</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Samuel Robertson</b>					
14. MOTHER'S MAIDEN NAME <b>Ella White</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)			
16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT <b>Husband, Mr. Gilbert Lake, # 2, a, b, c, d</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive &amp; Arteriosclerotic Cardiovascular disease</b> DUE TO (b) <b>Cerebral Thrombosis, with lt hemiplegia &amp; Aphasia</b> DUE TO (c) <b>Chronic Pyelonephritis</b> 443 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH <b>years.</b> <b>3 years.</b> <b>3 years.</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from <b>April 1963</b> , to <b>Feb. 5 1966</b> , that (I) (we) last saw the deceased alive on <b>Feb. 5 1966</b> , and that death occurred at <b>3 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Atallah Golpira</b>				22b. DATE SIGNED <b>Feb. 7-1966</b>			
22c. PHYSICIAN'S NAME (Type) <b>Atallah Golpira M.D.</b>				22d. ADDRESS <b>1942 Cedar Lane, Dundalk, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY			
<b>Burial</b>		<b>Feb. 9-1966</b>		<b>Sacred Heart of Jesus Dundalk, Bal. Co. Md.</b>			
24. FUNERAL DIRECTOR <b>JOHN J. DUDA, Dundalk, Md. 21222</b>				25a. REC'D BY REGISTRAR <b>DATE 3 3 1966</b>			
				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

# MARYLAND STATE DEPARTMENT OF HEALTH

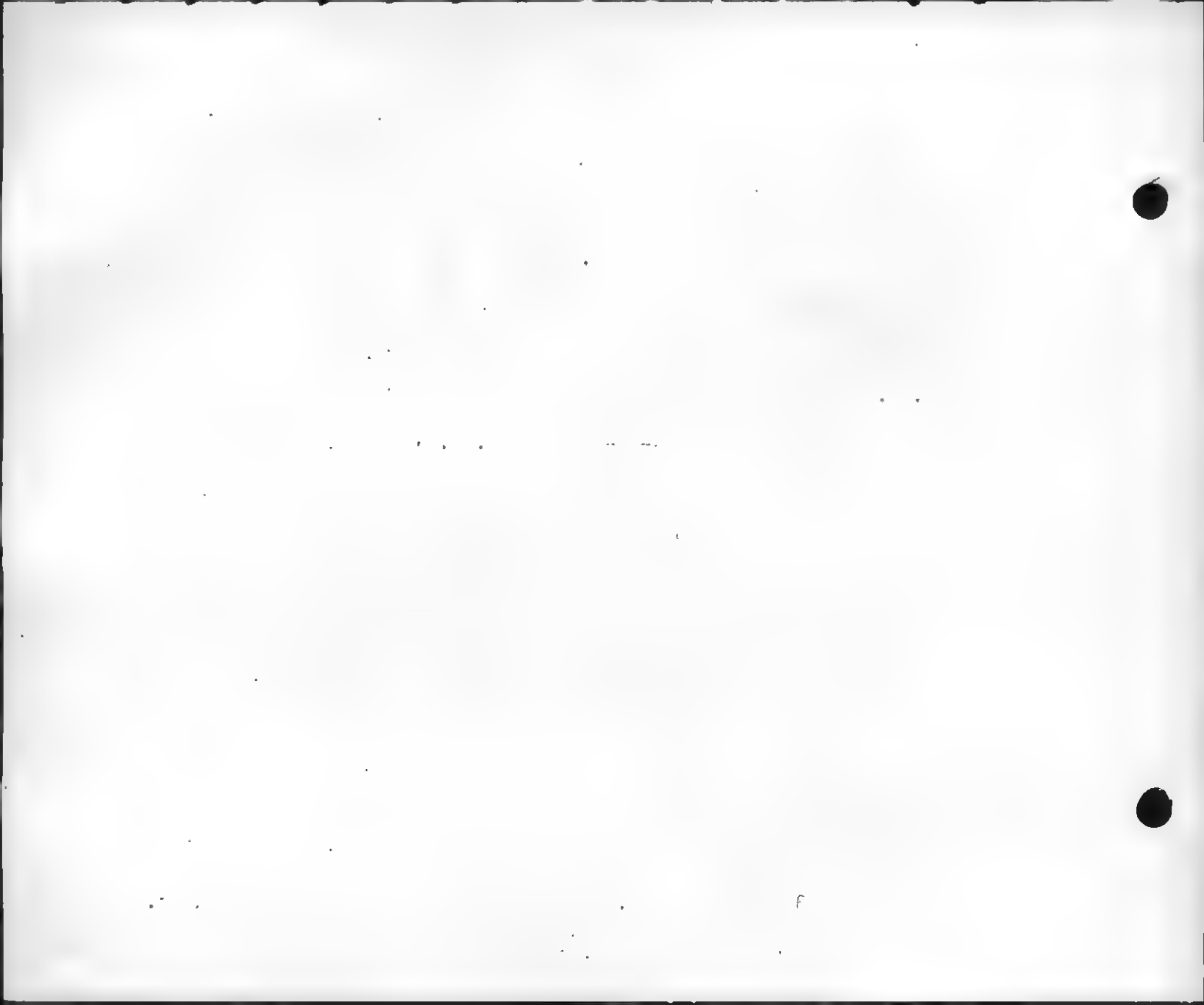
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01968

## CERTIFICATE OF DEATH

01916

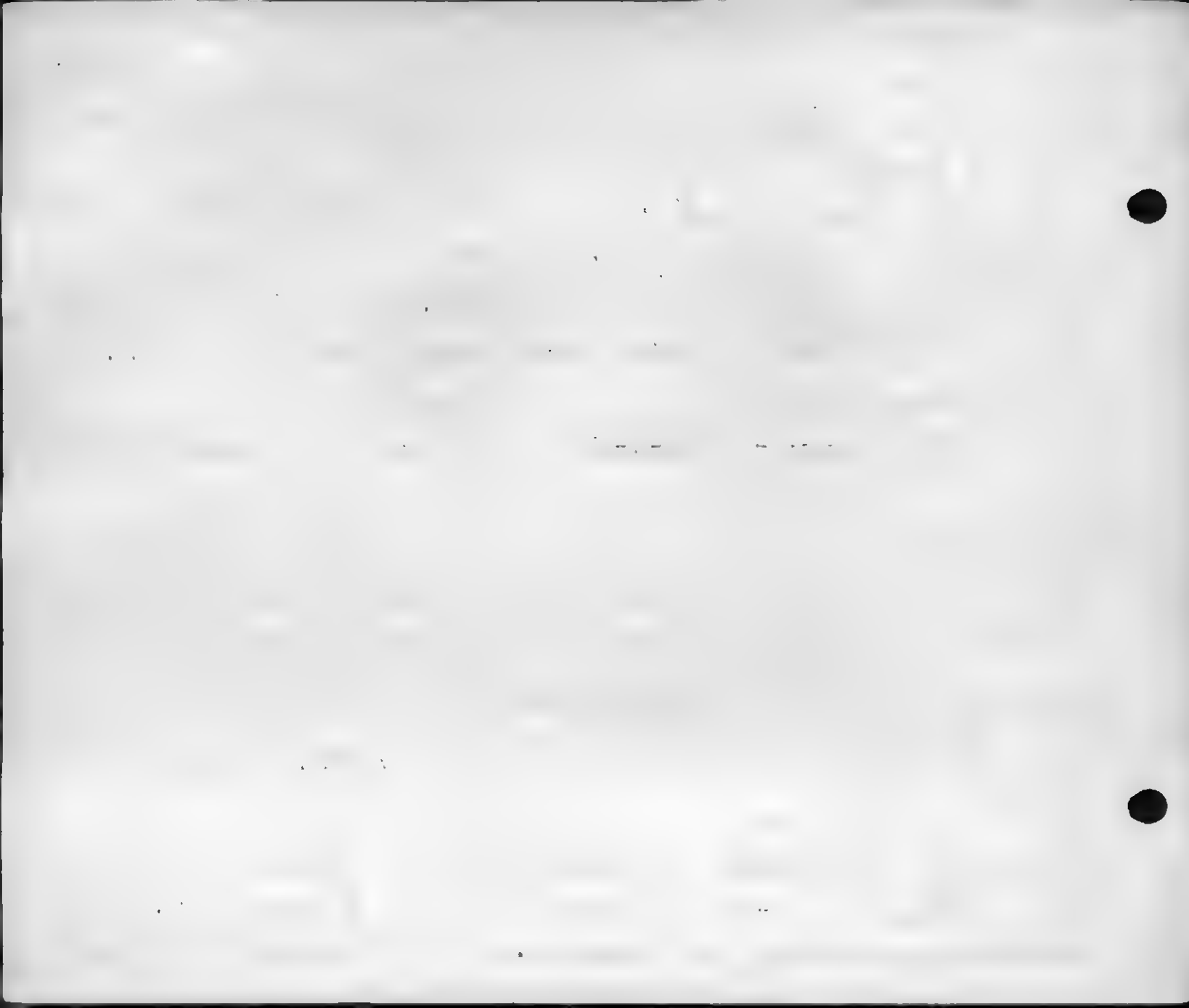
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Holbrook</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Pikesville</b>		
c. LENGTH OF STAY IN 1b <b>Chapel Hill Nursing Home</b> <b>Liberty and Robinson Roads</b>			d. STREET ADDRESS <b>508 Sudbrook Road 8</b>		
3. NAME OF DECEASED (Type or print) First <b>Lena</b> Middle <b>D.</b> Last <b>Lang</b>			4. DATE Month <b>February</b> Day <b>28</b> Year <b>1966</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 21, 1876</b>	9. AGE (in years last birthday) <b>89</b> yrs.	IF UNDER 1 YEAR: Months <b>89</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>J. P. Schlesinger</b>			14. MOTHER'S MAIDEN NAME <b>?</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-10-7952</b>		17. INFORMANT <b>Mrs. B. Nost</b> Address <b>same address as above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>UREMIA</b> DUE TO (b) <b>Nephrosclerosis</b> DUE TO (c) <b>?</b>					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Senility and Generalized Arteriosclerosis</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <b>2-17-</b> 1966, to <b>2-28-</b> 1966, that (I) (we) last saw the deceased alive on <b>2-28-1966</b> , and that death occurred at <b>4 A.M.</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>Cesar Valle Caverio</b>			22b. DATE SIGNED <b>2-28-66</b>		
22c. PHYSICIAN'S NAME (Type) <b>CESAR VALLE CAVERO</b>			22d. ADDRESS <b>8629 LIBERTY RD</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>2/2/1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Pauls Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Violetville, Md.</b>		
24. FUNERAL DIRECTOR <b>Wm. J. Johnson &amp; Sons</b>			25a. REC'D BY REGISTRAR <b>Charles Judge</b>		
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			DATE <b>MAR 1 1966</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
01969  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
01917

1. PLACE OF DEATH e. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eastwood</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eastwood</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7213 Gough Street 21224</u>				d. STREET ADDRESS <u>7213 Gough Street 21224</u>			
3. NAME OF DECEASED (Type or print) <u>John F. Lease</u>				4. DATE OF DEATH <u>February 6, 1966</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 20, 1908</u>	
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Color Blender</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Color Blender</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>American Standard</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Bellona, Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Stanley Lease</u>				14. MOTHER'S MAIDEN NAME <u>Valerie ?</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>213-01-4179</u>			
17. INFORMANT <u>Augusta Lease</u>				Address <u>7213 Gough Street 21224</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchogenic Carcinoma</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour <u>  </u> a.m. <u>  </u> p.m. <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <u>Nov. 11, 1963</u> to <u>Sept. 27, 1965</u> , that (I) (we) last saw the deceased alive on <u>Feb. 1, 1966</u> , and that death occurred at <u>11:59 A.M.</u> from the causes and on the date stated above							
22a. SIGNATURE <u>Manuel P. De Leon</u>				22b. DATE <u>Feb 8, 1966</u>			
22c. PHYSICIAN'S NAME (Type or print) <u>MANUEL P. DE LEON M.D.</u>				22d. ADDRESS <u>7840 Eastern Ave. Bkpt. 24</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-9-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Holy Rosary Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore County, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Charles S. Judge</u>				25a. REC'D BY REGISTRAR <u>Feb 11 1966</u>			
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01918

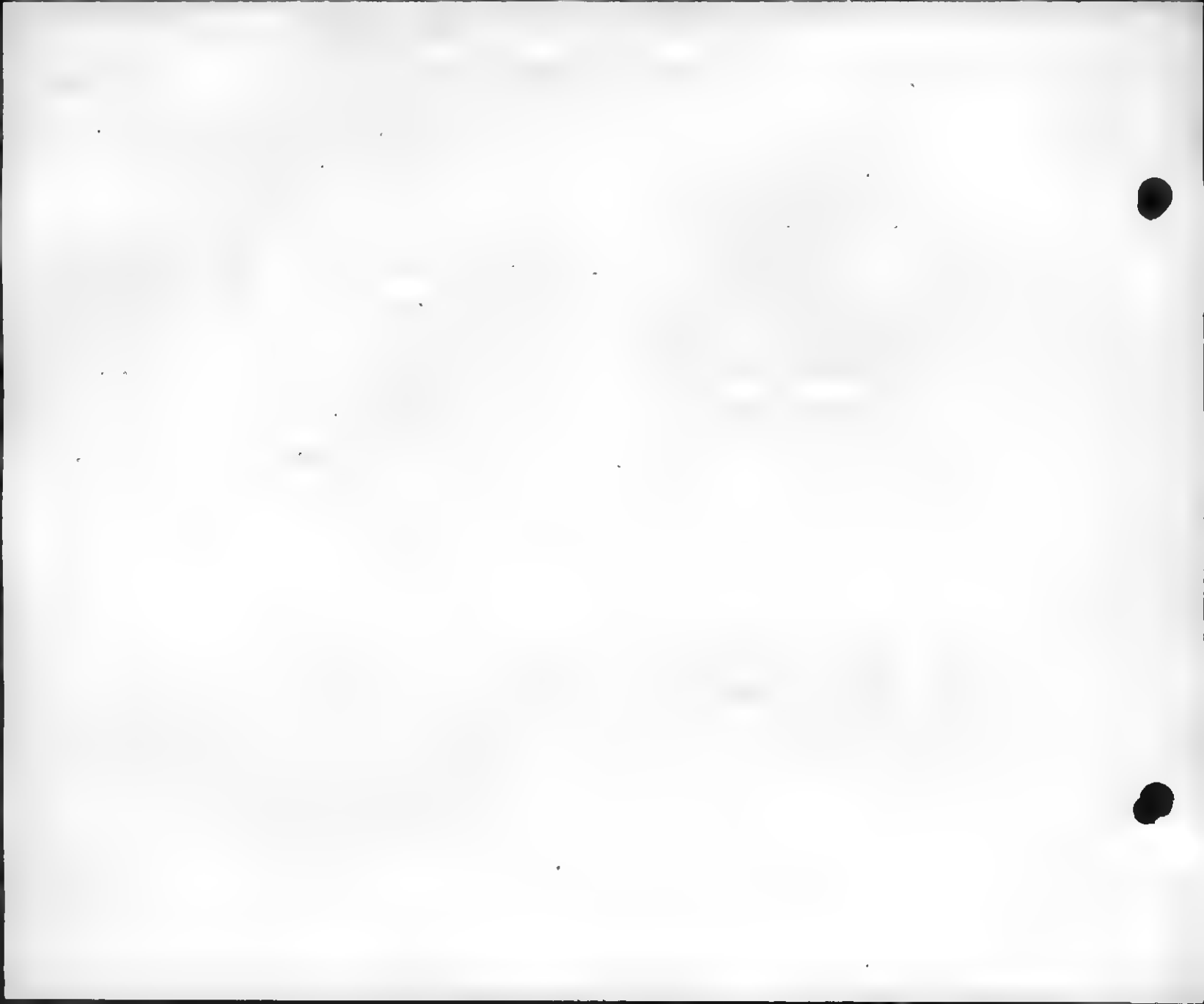
FOR STATE  
HEALTH DEPT

M

01970

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Randallstown</b>				c. LENGTH OF STAY IN TOWN <b>1 hour</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Balto. Co. Gen. Hospital</b>				e. STREET ADDRESS			
3 NAME OF DECEASED (Type or print) First Middle Last <b>Gurney O. Leatherwood</b>				4 DATE OF DEATH Month Day Year <b>Feb. 25 1966</b>			
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>6-7-1900</b>	9 AGE (In years last birthday) <b>65</b> yrs	10 IF UNDER 1 YEAR Months Days Hours Min		11 IF UNDER 24 HRS Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Auto Mechanic - Retired</b>			10b KIND OF BUSINESS OR INDUSTRY <b>Auto</b>		11 BIRTHPLACE (State or foreign country) <b>Md.</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Vivian Leatherwood</b>				14 MOTHER'S MAIDEN NAME <b>Florence Alexander</b>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) (If yes give war or dates of service) <b>no</b>		16 SOCIAL SECURITY NO <b>214-16-1447</b>		17 INFORMANT Address <b>Mrs. Helen Leatherwood, Sykesville, Md.</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Arteriosclerotic C-V Disease</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b> <b>1 yr</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> <b>none</b>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>none 19</b>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>D.D. Caples</b>		EXAMINER'S NAME (Type) <b>D. D. Caples, M. D., 6 Hanover Rd., Randallstown, Md.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <b>2-25-66</b>	
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE THEREOF <b>2-28-66</b>		23c NAME OF CEMETERY OR CREMATORY <b>Old Oakland</b>		23d LOCATION (City or town) (County) (State) <b>Sykesville Carroll Md</b>	
24 FUNERAL DIRECTOR <b>Arthur H. Haight Sykesville, Md.</b>		ADDRESS		25a REC'D BY REGISTRAR <b>MAR 1 1966</b>		25b REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
20M 1/65

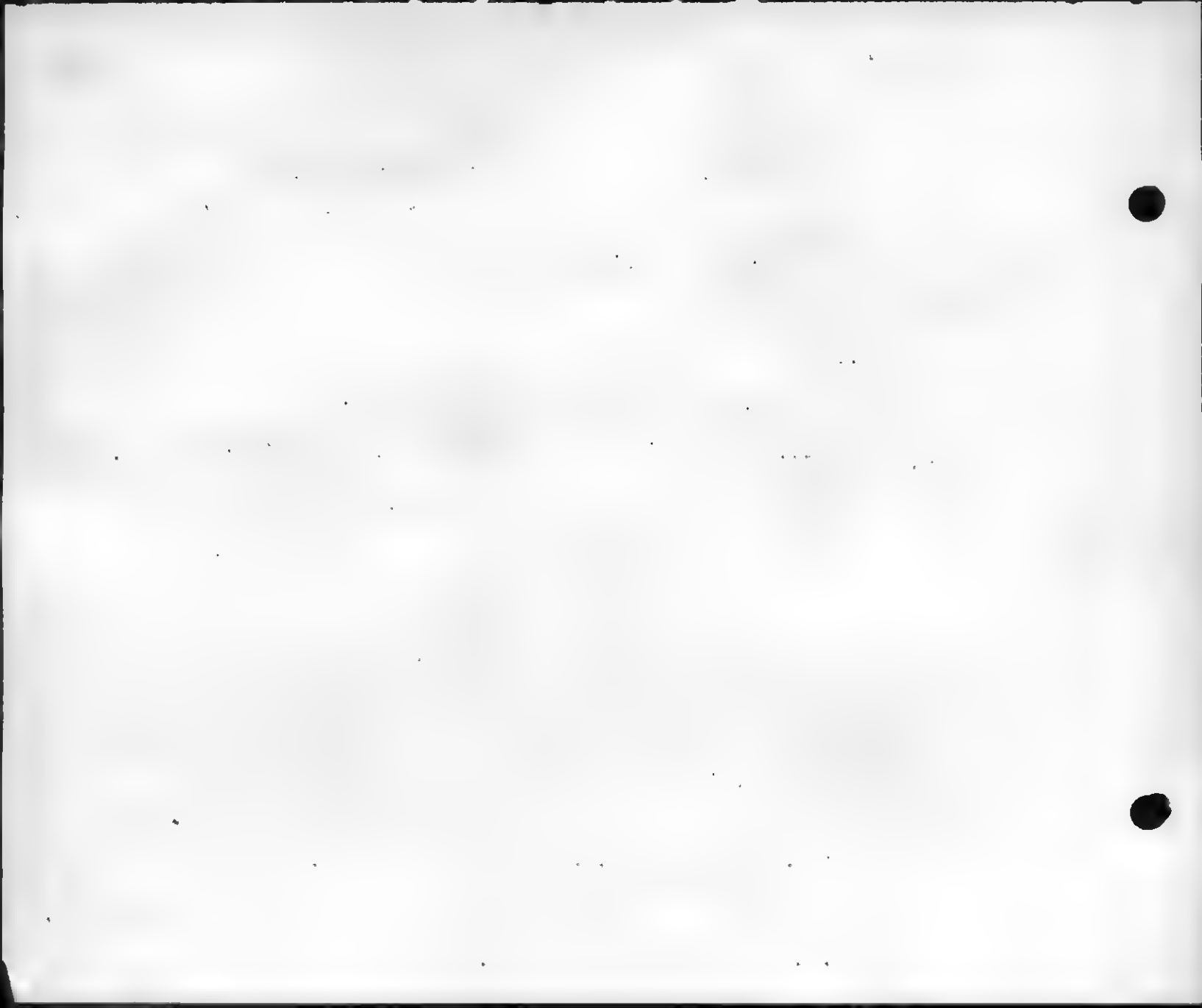
01971

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

01919

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>St. Joseph Hospital</u>				d. STREET ADDRESS <u>7302 Dunbrook Court 21222</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Joseph Stephen Lechert, Jr.</u>				4. DATE OF DEATH Month <u>2</u> Day <u>9</u> Year <u>19 66</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/9/66</u>		9. AGE (in years last birthday) yrs. <u>14</u>		10. IF UNDER 1 YEAR Months <u>14</u> Days <u>14</u> Hours <u>14</u> Min. <u>14</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <u>Joseph Leckert, Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Joann Fischer</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Joseph Leckert</u>		Address <u>7302 Dunbrook Ct. 21222</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Petechial hemorrhage of lungs, brain, small intestines.</u> 610 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Patent foramen ovale</u> OUE TO (c) <u>Cephalhematoma, right occipital.</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not White at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>2/9/</u> , 19 <u>66</u> , to <u>2/9/</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2/9/</u> , 19 <u>66</u> , and that death occurred at <u>12:25</u> M., from the causes and on the date stated above.							
22a. SIGNATURE <u>D.R. Govinda Rao</u> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>2/10/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>D.R. Govinda Rao, M.D.</u>				22d. ADDRESS <u>7620 York Rd., Baltimore, Md. 21204</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-11-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gardens of Faith</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore County Md.</u>	
24. FUNERAL DIRECTOR <u>Charles S. Zeiler</u>		ADDRESS <u>6224 Eastern Ave. #24</u>		25a. REC'D BY REGISTRAR <u>FEB 14 1966</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

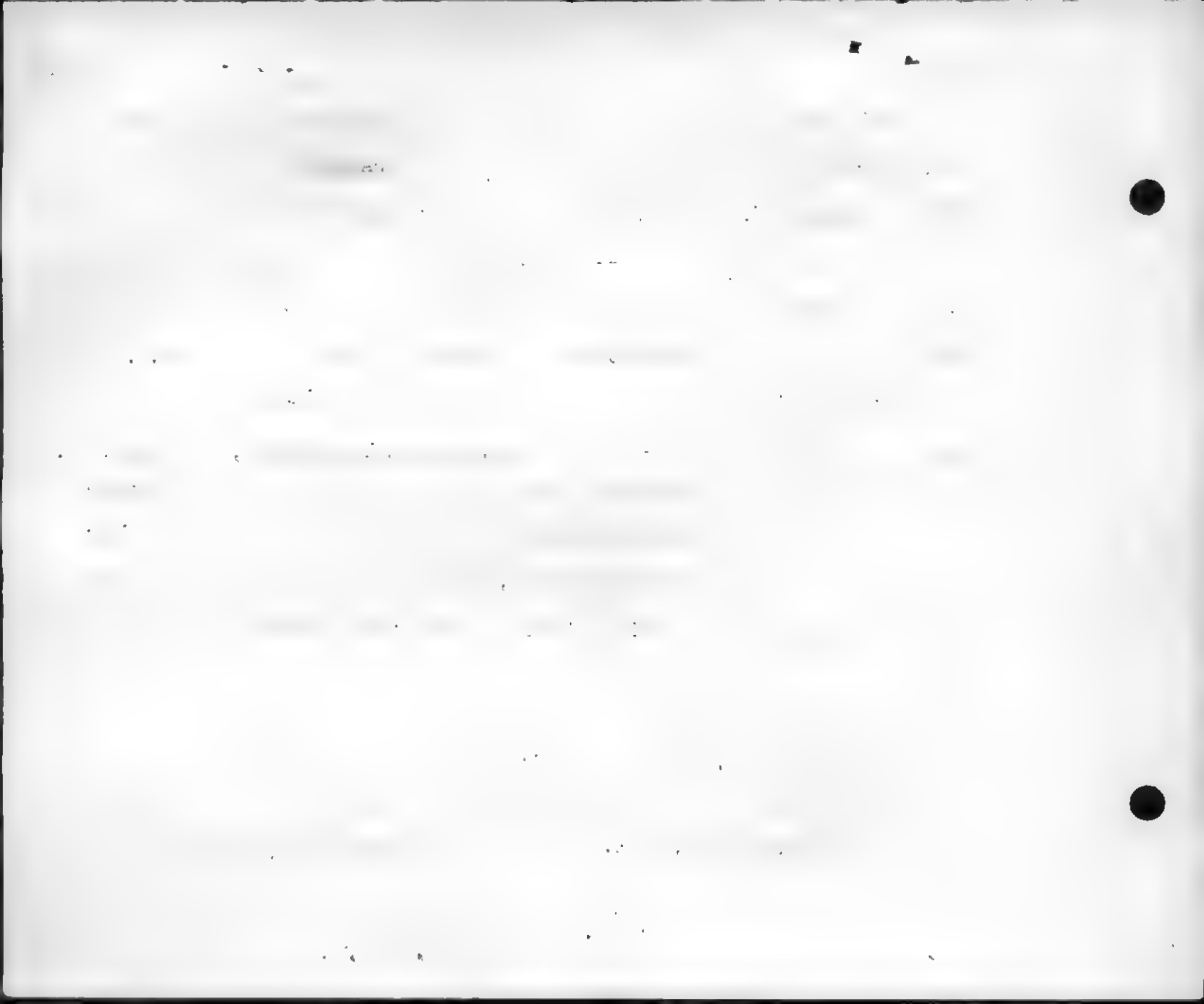
MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b> c. LENGTH OF STAY IN 1b <b>11 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WICOMICO</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>SALTSBURY</b> d. STREET ADDRESS <b>553 EAST ROAD</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>FRED</b>			First Middle Last <b>LEE</b>			4. DATE OF DEATH <b>FEBRUARY 5 19 66</b>		Day Year	
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>NEGRO</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/9/09</b>		9. AGE (in years last birthday) <b>56</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION</b>		11. BIRTHPLACE (County & State, or foreign country) <b>CENTURY, FLORIDA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>EDGAR BRADLEY</b>					14. MOTHER'S MAIDEN NAME <b>IDA MAE MILLER</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>			16. SOCIAL SECURITY NO. <b>WW II 264-20-3000</b>		17. INFORMANT <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY EDEMA</b> OUE TO <b>PULMONARY EMBOLUS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>THROMBOPHLEBITIS, LEGS</b> (b) <b>THROMBOPHLEBITIS, LEGS</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ANEURYSM OF AORTA DUE TO SYPHILLIS WITH AORTIC INSUFFICIENCY</b>								INTERVAL BETWEEN ONSET AND DEATH HOURS HOURS DAYS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office/bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>2/25/66</b> , 19 <b>66</b> , to <b>2/5/66</b> , 19 <b>66</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>2/5/66</b> , 19 <b>66</b> , and that death occurred <b>6:45 PM</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>George Dudas</b>					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>2/8/66</b>		
22c. PHYSICIAN'S NAME (Type) <b>GEORGE DUDAS, M. D.</b>					22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE THEREOF <b>2-10-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Balti Nat Cml</b>		23d. LOCATION (City, town or county) (State) <b>Balti Md</b>		
24. FUNERAL DIRECTOR <b>C. C. Wilson</b>					25. REC'D BY REGISTRAR <b>Elroy U. Wilson</b> 25b. REGISTRAR'S SIGNATURE <b>Elroy U. Wilson</b> <b>Orleans Street, Baltimore, Md.</b> <b>9 1966</b>				



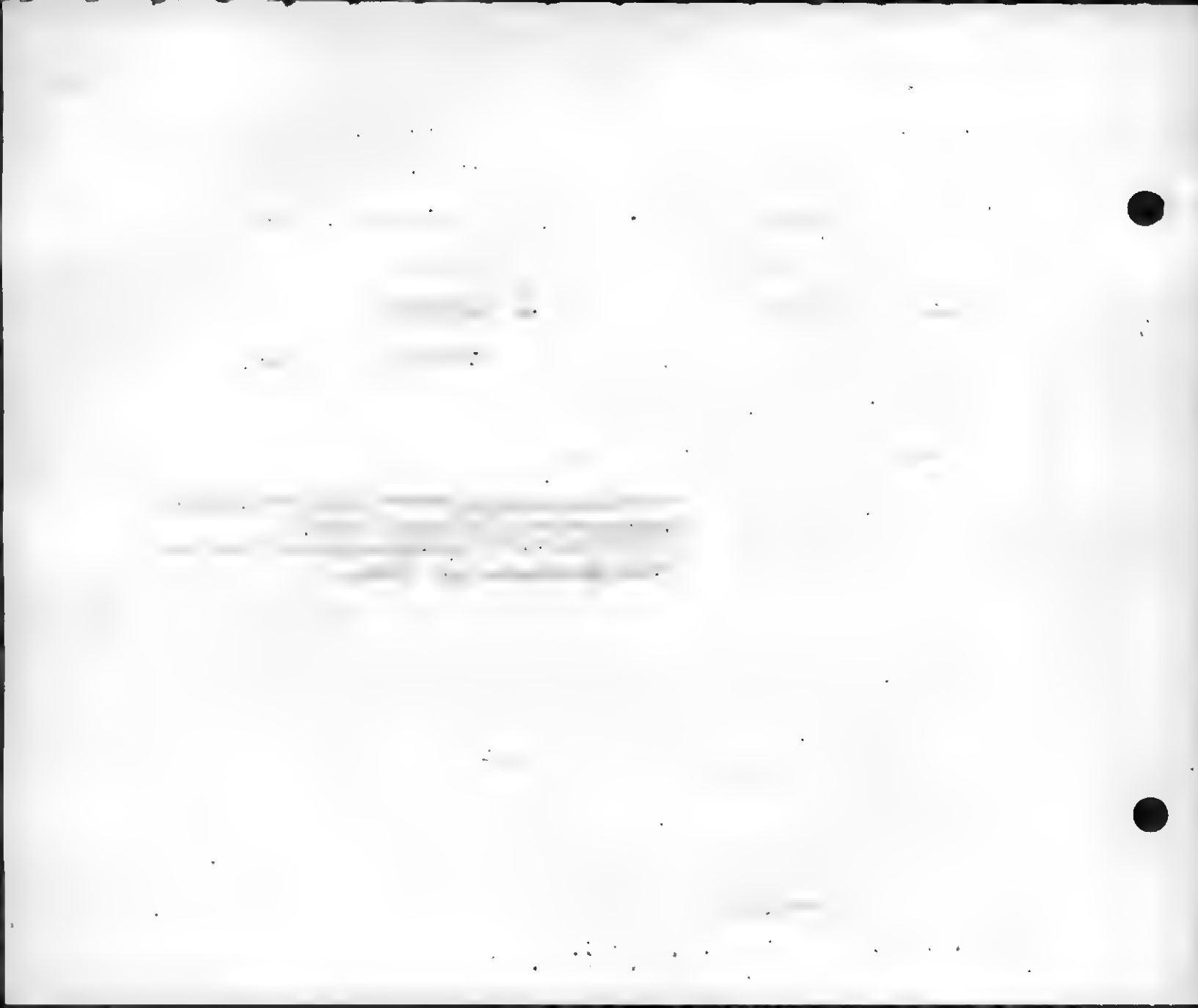
1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01973

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

01921

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b> c. LENGTH OF STAY IN ID <b>18</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>GREATER BALTIMORE MEDICAL CENTER</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> d. STREET ADDRESS <b>3904 HADLEY SE, W. 1ST</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>LUCILLE</b> First <b>S.</b> Middle <b>LEE</b> Last		4. DATE OF DEATH <b>FEB</b> Month <b>25</b> Day <b>1966</b> Year		5. SEX <b>FEMALE</b> 6. COLOR OR RACE <b>WHITE</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>4/16/1921</b> 9. AGE (in years last birthday) <b>44</b> yrs. 10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>		11. BIRTHPLACE (County & State, or foreign country) <b>BROOKLYN, NEW YORK</b> 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>JOHN ARMISTEAD SPILMAN</b> 14. MOTHER'S MAIDEN NAME <b>LUCILE MARTIN</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b> 16. SOCIAL SECURITY NO. <b>200-20-9291</b> 17. INFORMANT <b>ALICE HISTORY</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CC Cardiac arrest Cerebral edema</b> DUE TO <b>Carcinoma of lung with</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>on of lung of aneurysm rupture</b> DUE TO <b>metastases to brain</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH <b>few min</b> <b>about 1 yr</b> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2/20</b> , 19 <b>66</b> , to <b>2/25</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>2/25</b> , 19 <b>66</b> , and that death occurred at <b>2:35</b> A.M. from the causes and on the date stated above.							
22a. SIGNATURE <b>Lucille A Torres</b> 22c. PHYSICIAN'S NAME (Type) <b>Lucille A Torres</b>				22b. DATE SIGNED <b>2-25-66</b> 22d. ADDRESS <b>Greater Baltimore Medical Center</b> M.O. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/26/1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>		23d. LOCATION (City, town or county) (State) <b>Pikesville, Balto. Co. Md.</b>	
24. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co.</b> ADDRESS <b>4905 York Rd. Balto. 12, Md.</b>				25a. REC'D BY REGISTRAR <b>28 1966</b> 25b. REGISTRAR'S SIGNATURE <b>William Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

1974

0-922

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <span style="float:right">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u> c. LENGTH OF STAY IN TB d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Dulaney-Towson Nursing Home</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> <span style="float:right">b. COUNTY <u>Baltimore</u></span> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Ruxton</u> d. STREET ADDRESS <u>1402 Locust Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) <u>Leonard M. Levering</u>				<b>4. DATE OF DEATH</b> Month <u>February</u> Day <u>21</u> Year <u>1966</u>					
<b>5. SEX</b> <u>M</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>May 22, 1886</u>		<b>9. AGE</b> (in years last birthday) <u>79</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u> IF UNDER 24 HRS.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Executive</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Insurance</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Baltimore, Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Edwin W. Levering</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Gould</u>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <u>219-30-6827</u>		<b>17. INFORMANT</b> <u>Leonard M. Levering, Jr.</u> Address <u>1402 Locust Ave.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> 4201 <span style="margin-left: 100px;">DUE TO</span> <u>ARTERIOSCLEROTIC HEART DISEASE</u> <span style="float:right">INTERVAL BETWEEN ONSET AND DEATH <u>2-3 YRS.</u></span> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <span style="margin-left: 100px;">DUE TO</span> (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>BRONCHIECTASIS</u> <u>DEPRESSION</u>									
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>DR CONTRIBUTING</b> <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from <u>JULY 27, 1964</u>, to <u>FEB. 21, 1966</u>, that (I) (we) last saw the deceased alive on <u>FEB. 3, 1966</u>, and that death occurred at <u>9 P.M.</u> from the causes and on the date stated above.</b>									
<b>22a. SIGNATURE</b> <u>Carlton L. Sexton</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						<b>22b. DATE SIGNED</b> <u>2-22-66</u>			
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Dr. Carlton L. Sexton</u>						<b>22d. ADDRESS</b> <u>819 Park Ave.</u>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>2/24/1966</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Saters Baptist</u>		<b>23d. LOCATION (City, town or county) (State)</b> <u>Falls Road Md.</u>			
<b>24. FUNERAL DIRECTOR</b> <u>H.W. Jenkins &amp; Sons Co.</u> ADDRESS <u>4905 York Road Balto. 12, Md.</u>						<b>25a. REC'D BY REGISTRAR</b> <b>25b. REGISTRAR'S SIGNATURE</b> DATE <u>FEB 23 1966</u> <u>Charles Judge</u>			

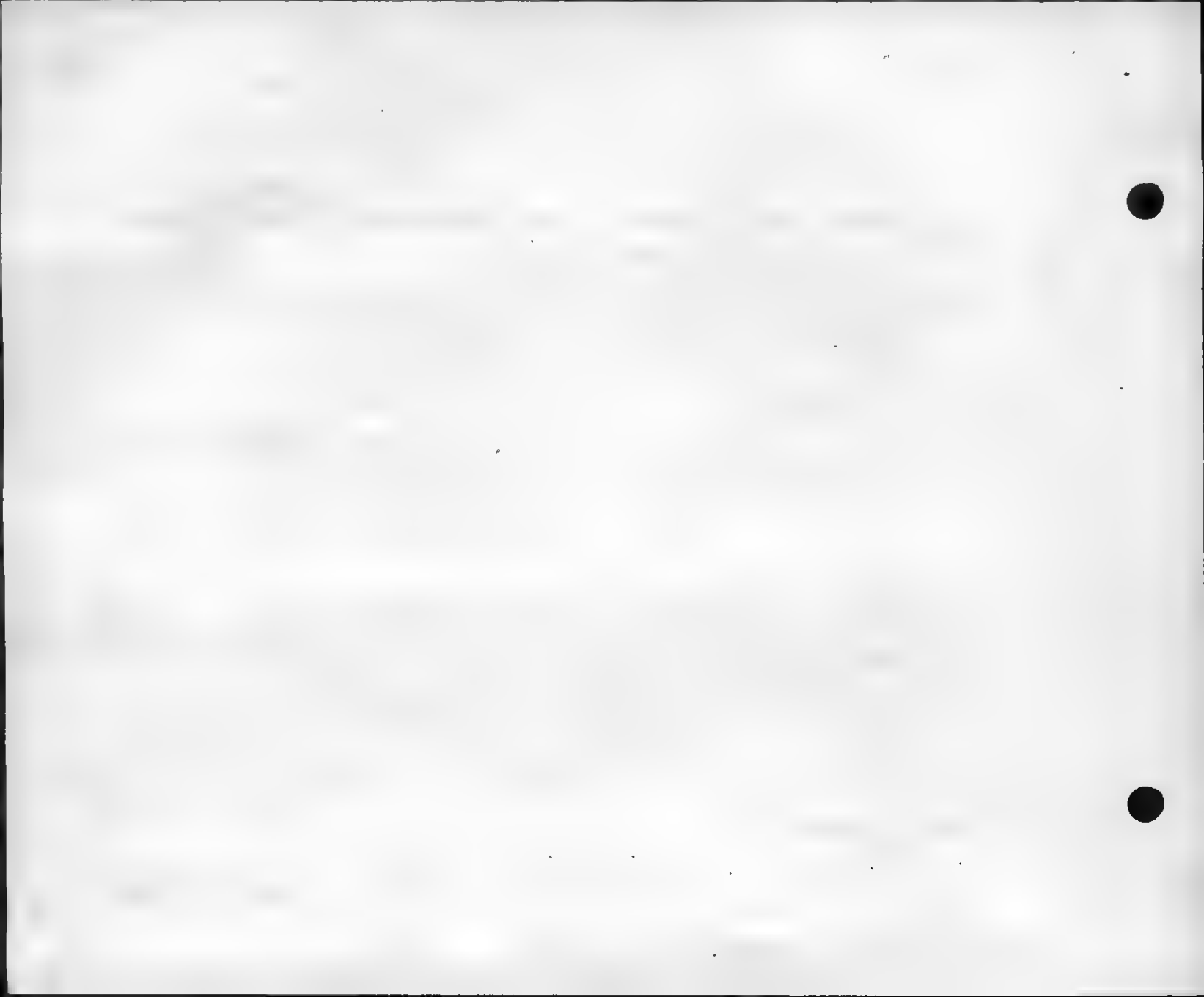


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY IN ID <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baltimore County General Hosp.</u>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, If Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> d. STREET ADDRESS <u>5005 CORDELIA AVENUE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) <u>Rose</u> (Type or print)			<b>First</b> <u>Rose</u> <b>Middle</b> <u>(BAZENSKY)</u> <b>Last</b> <u>Levin</u>			<b>4. DATE OF DEATH</b> Month <u>February</u> Day <u>17</u> Year <u>1966</u>					
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>12/22/1888</u>		<b>9. AGE</b> (In years last birthday) <u>77</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u> <b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>AT HOME</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>POLAND</u>		<b>12. CITIZEN OF WHAT COUNTRY</b> <u>USA</u>			
<b>13. FATHER'S NAME</b> <u>? WINDMAN</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>?</u>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <u>NO</u>		<b>17. INFORMANT</b> <u>MRS. DORIS KALIN</u>		<b>Address</b> <u>4321 KENNISON AVENUE</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 260X <b>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST,</b> DUE TO (b) <u>Arterio Sclerotic Heart Disease</u> DUE TO (c) <u>Diabetes Mellitus</u>										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>  </u>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>											
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that (I) (this hospital) attended the deceased from <u>2-12</u>, 19<u>66</u>, to <u>2-17</u>, 19<u>66</u>, that (I) (we) last saw the deceased alive on <u>2-17</u>, 19<u>66</u>, and that death occurred at <u>10:45</u> AM, from the causes and on the date stated above.</b>											
<b>22a. SIGNATURE</b> <u>DR. BIENVENIDO A. CABUAY</u>						<b>22b. DATE SIGNED</b> <u>2/17/66</u>		<b>22c. PHYSICIAN'S NAME (Type)</b> <u>DR. BIENVENIDO A. CABUAY</u>			
<b>22d. ADDRESS</b> <u>Baltimore County Gen. Hosp.</u>						<b>22e. ADDRESS</b> <u>Baltimore County Gen. Hosp.</u>					
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>				<b>23b. DATE THEREOF</b> <u>2/20/66</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>WORKMENS CIRCLE</u>		<b>23d. LOCATION (City, town or county)</b> (State) <u>BALTIMORE, MARYLAND</u>			
<b>24. FUNERAL DIRECTOR</b> <u>SOL LEVINSON &amp; BROS. INC. 6010 REISTERSTOWN RD</u>						<b>25a. REC'D BY REGISTRAR</b> <u>FEB 23 1966</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01976

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01924

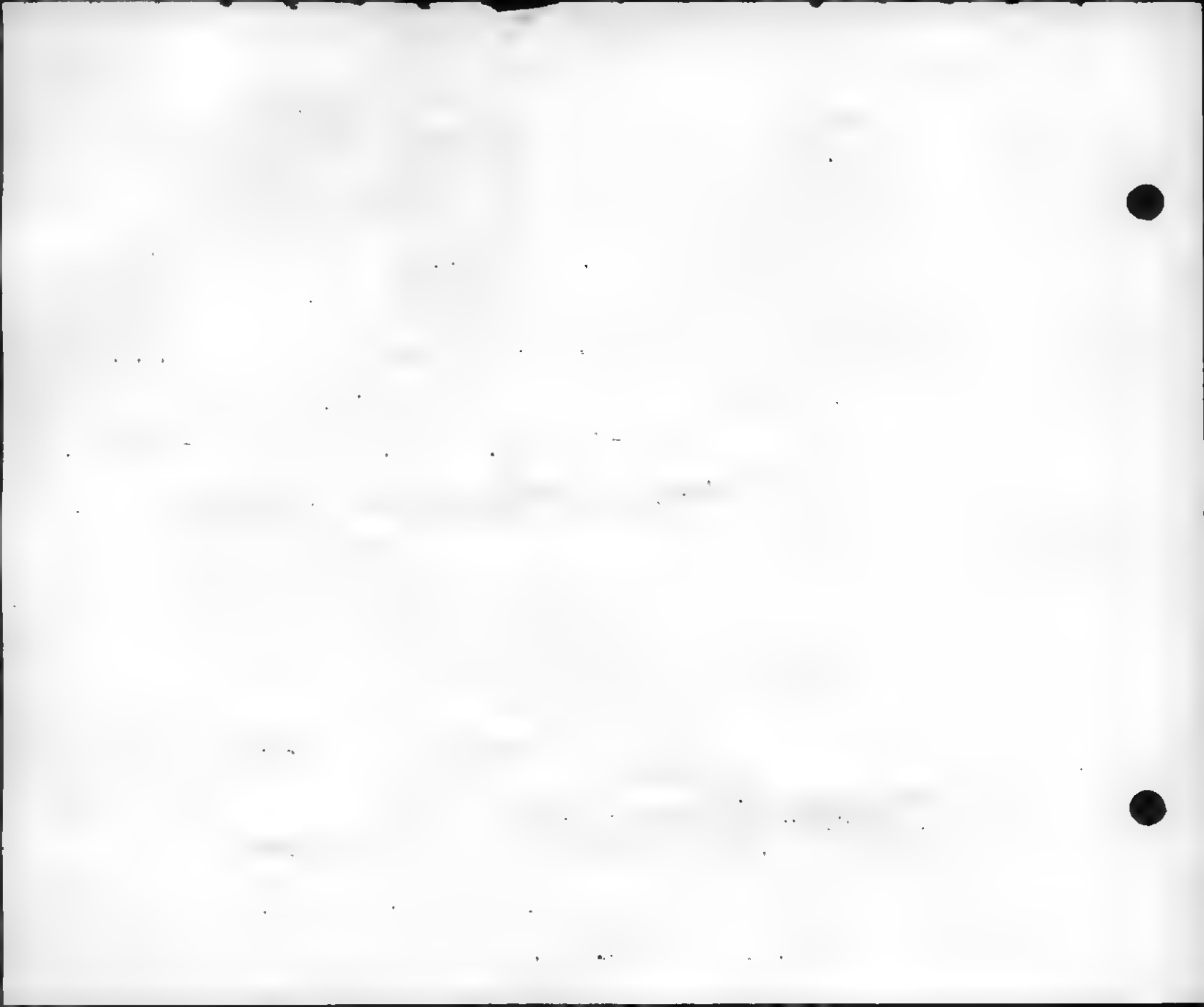
1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lutherville</b> c. LENGTH OF STAY IN 1b <b>since 1961</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>College Manor</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore City</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>Northway Apartments--21218</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>KATHARINE BECRAFT LEVY</b>			4. DATE OF DEATH Month <b>February</b> Day <b>11</b> Year <b>1966</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>	8. DATE OF BIRTH <b>October-16-1872</b>	9. AGE (In years last birthday) <b>93 yrs.</b>	10. UNDER 1 YEAR <input type="checkbox"/> UNDER 24 HRS. <input type="checkbox"/> Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			13. FATHER'S NAME <b>John Becraft</b>				
14. MOTHER'S MAIDEN NAME <b>Amelia Maykrantz</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>				
16. SOCIAL SECURITY NO. <b>216-46-3967</b>		17. INFORMANT <b>Karl M. Levy (son) Fidelity Bldg. Baltimore</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerosis</b> <b>4500</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>11-28, 1949</b> to <b>2-1, 1966</b> , that (I) (we) last saw the deceased alive on <b>Feb 19 66</b> , and that death occurred at <b>7:30M</b> , from the causes and on the date stated above.					
22a. SIGNATURE <b>W. G. Helfrich</b>		22b. DATE SIGNED <b>2-12-66</b>		22c. PHYSICIAN'S NAME (Type) <b>Dr. William G. Helfrich</b>			
22d. ADDRESS <b>5006 Roland Avenue, Batto. 21210</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>					
23b. DATE THEREOF <b>Feb. 14, 66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>		23d. LOCATION (City, town or county) (State) <b>Woodlawn, Md. 21207</b>			
24. FUNERAL DIRECTOR <b>Stewart &amp; Mowen Co 108--North-Av 21201</b>		25a. REC'D BY REGISTRAR <b>Feb 14 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
01973									
01925									
1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>ROSEMONT</b> c. LENGTH OF STAY IN ID <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>2814 LOUISIANA AVENUE 21227</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>ROSEMONT</b> d. STREET ADDRESS <b>2814 LOUISIANA AVENUE 21227</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>MARION</b> Middle <b>B.</b> Last <b>LEWIS</b>			4. DATE OF DEATH Month <b>2</b> Day <b>26</b> Year <b>1966</b>						
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/2/1899</b>		9. AGE (in years last birthday) <b>67</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>CHIEF SHIPPING CLERK</b>			11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN - LEWIS</b>					14. MOTHER'S MAIDEN NAME <b>UNKNOWN AGNES -----</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>			16. SOCIAL SECURITY NO. <b>214-02-1212</b>		17. INFORMANT (LEWIS) (Louisiana) <b>MRS. ALICE V. LEWIS, 2814 LOUISIANA AVE. #27</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Malignant Lymphoma, follicular type</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____									19. INTERVAL BETWEEN ONSET AND DEATH <b>3 1/2 yrs</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>4/7/61</b> , 19____, to <b>Feb 26</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>2/22/66</b> , 19____, and that death occurred at <b>1 P</b> M, from the causes and on the date stated above.									
22a. SIGNATURE <b>C. Arthur Rosenberg MD</b>					22b. DATE SIGNED <b>3/1/66</b>		22c. PHYSICIAN'S NAME (Type) <b>C. ARTHUR ROSENBERG</b>		
22d. ADDRESS <b>2436 WASHINGTON BOULEVARD</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE THEREOF <b>3/2/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MEADOWRIDGE MEMORIAL PARK</b>		23d. LOCATION (City, town or county) (State) <b>BALTIMORE, MARYLAND</b>		
24. FUNERAL DIRECTOR <b>HUBBARD FUNERAL HOME, 4107 WILKENS AVE. 21229</b>					25a. REC'D BY REGISTRAR <b>MAR 4 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Jones</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

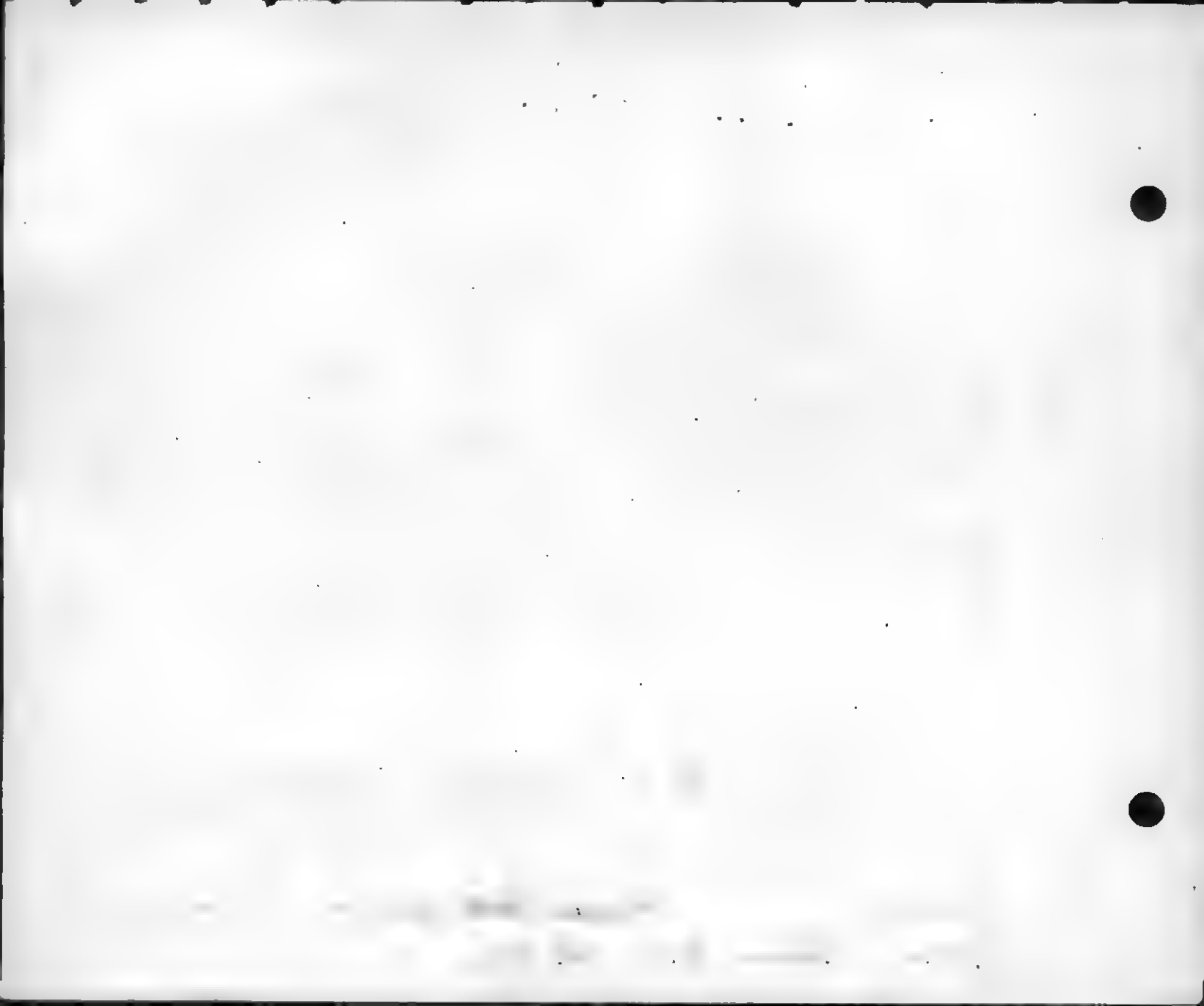
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

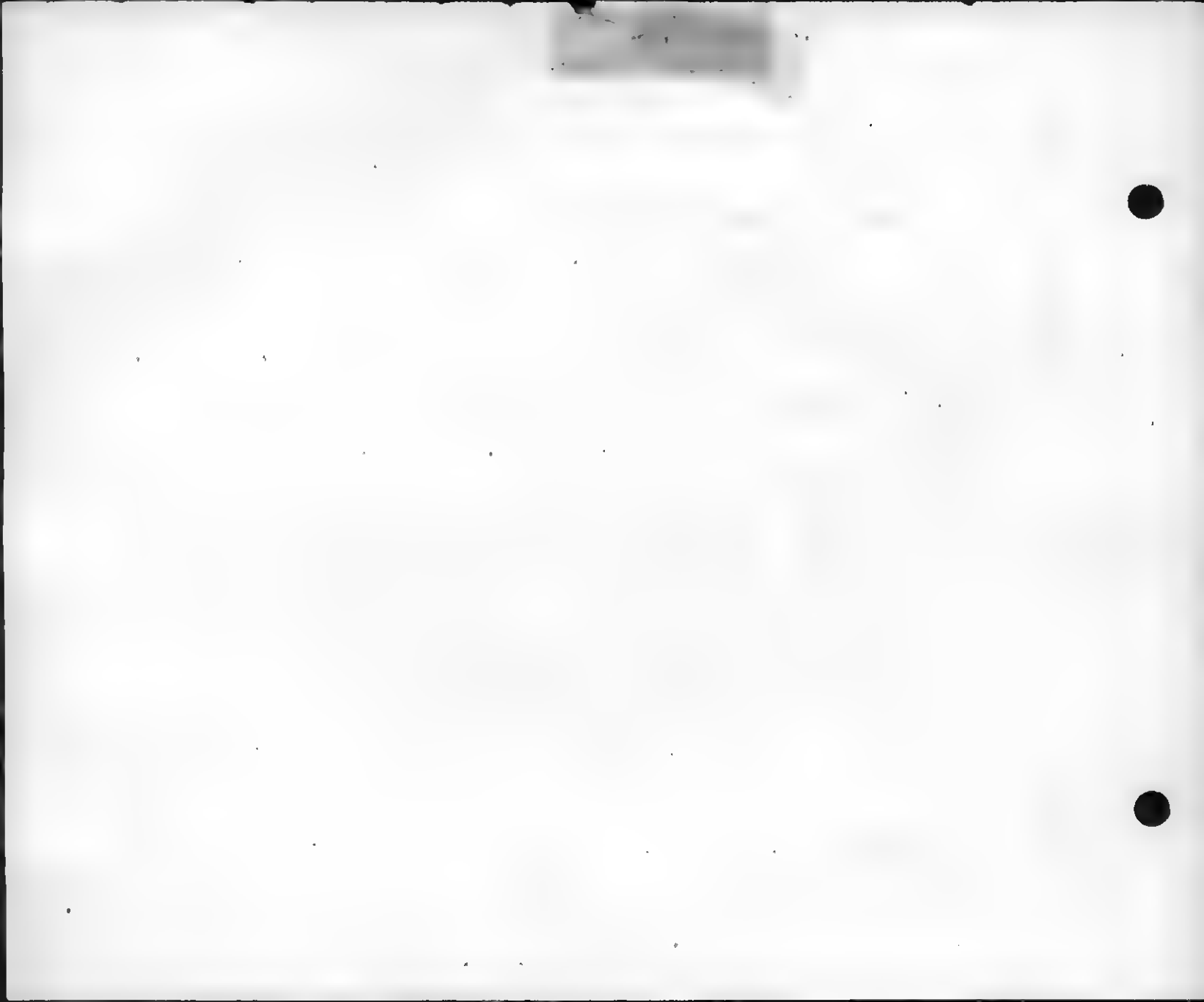
01926

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
c. LENGTH OF STAY IN 1b <u>6x1</u>				d. STREET ADDRESS <u>N. Charles St</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>GREATER BALTIMORE MED CENTER</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>LINSEN MAYER Baby Boy</u>				4. DATE OF DEATH <u>2/24</u> 19 <u>66</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/23/66</u>	
9. AGE (In years last birthday) <u>2</u> yrs.		10. IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u> Min. <u>18</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>New Born</u>				10b. KIND OF BUSINESS OR INDUSTRY <u></u>			
13. FATHER'S NAME <u>Glenn Ross Linschmayer</u>				14. MOTHER'S MAIDEN NAME <u>Ann Louise SCHMIDT</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>N.B.</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT <u>Chart</u>		Address <u>603 HAMILTON PLACE</u> <u>914 N. Borne</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Alektaxis</u> DUE TO (b) <u>Prematurity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Hyaline Membrane Disease</u> DUE TO (c) <u>Hyaline Membrane Disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>24 hrs</u> <u>24 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NO</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>NO</u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>X</u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>X</u>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 23</u> , 19 <u>66</u> , to <u>Feb 24</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Feb 24</u> , 19 <u>66</u> , and that death occurred at <u>1:30 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Leonard S. Hoffman</u>				22b. DATE SIGNED <u>2/24/66</u>		22c. PHYSICIAN'S NAME (Type) <u>HOFFMAN LEONARD S. G.B.M.C. BACT. MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u>		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <u>Greater Balt. Md. Ctr. Towson, Md.</u>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR <u>John E. Adams, N.D. G.B.M.C.</u>				25a. REC'D BY REGISTRAR <u>1</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



10-6-1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
01979					01927					
1. PLACE OF DEATH a. COUNTY Baltimore					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson			c. LENGTH OF STAY IN 1b M. Livingston		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville,					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Chesapeake Manor Nursing Home					d. STREET ADDRESS 1215 Oak Croft Drive					
3. NAME OF DECEASED (Type or print) Anna		First M.		Middle Livingston		4. DATE OF DEATH Month February		Day 3		
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/1/1882		9. AGE (In years last birthday) 84 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Own Home			11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Rutledge					14. MOTHER'S MAIDEN NAME Jane Pool					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 217-14-1119		17. INFORMANT Mrs. Philip W. Kane		18. ADDRESS (Same)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral vascular accident</i> 4 hrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic C V Disease</i> 10 yrs DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									INTERVAL BETWEEN ONSET AND DEATH 2 hrs 10 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Jan 1966 to Feb 4, 1966, that (I) (we) last saw the deceased alive on Feb 3 1966, and that death occurred at 9 PM, from the causes and on the date stated above.										
22a. SIGNATURE Dr. Allan A. Spier					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Dr. Allan A. Spier					22d. ADDRESS 1501 Pentridge Road					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 2/5/1966		23c. NAME OF CEMETERY OR CREMATORY Loudon Park			23d. LOCATION (City, town or county) Baltimore Md.		
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Road Baltimore 12, Md.					25a. REC'D BY REGISTRAR DATE FEB 4 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01990

01028

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN 1b <b>Catonsville</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>In woods at Newberg Avenue</b>				2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> d. STREET ADDRESS <b>115 Osborne Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <b>REGINALD S. LIVINGSTON</b>				4 DATE OF DEATH Month <b>2</b> Day <b>28</b> Year <b>19 66</b>			
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Nov. 6, 1931</b>		9 AGE (in years last birthday) <b>34</b> yrs	IF UNDER 1 YEAR Months <b>2</b> Days <b>28</b>	IF UNDER 24 HRS. Hours <b>19</b> Min <b>66</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Accountant</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Kentucky</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>R. H. Stanley Livingston</b>				14. MOTHER'S MAIDEN NAME <b>Evelyn L. Lyons</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-28-5850</b>		17. INFORMANT Address <b>Mr. R. H. Stanley Livingston same address</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carbon monoxide poisoning</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) <b>Asphyxia due to carbon monoxide poisoning</b>					
20c. TIME OF INJURY Month Day Year Hour a.m. <b>2</b> p.m. <b>28</b> 1966		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Woods</b>		20f. (City or town) (County) (State) <b>Catonsville, Balto, Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
ACTUAL SIGNATURE <b>Russell S. Fisher, M.D.</b>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)				22. DATE SIGNED <b>2-28-66</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/4/1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>Wm. J. Fisher &amp; Son</b>				25a. REC'D BY REGISTRAR DATE <b>MAR 3 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

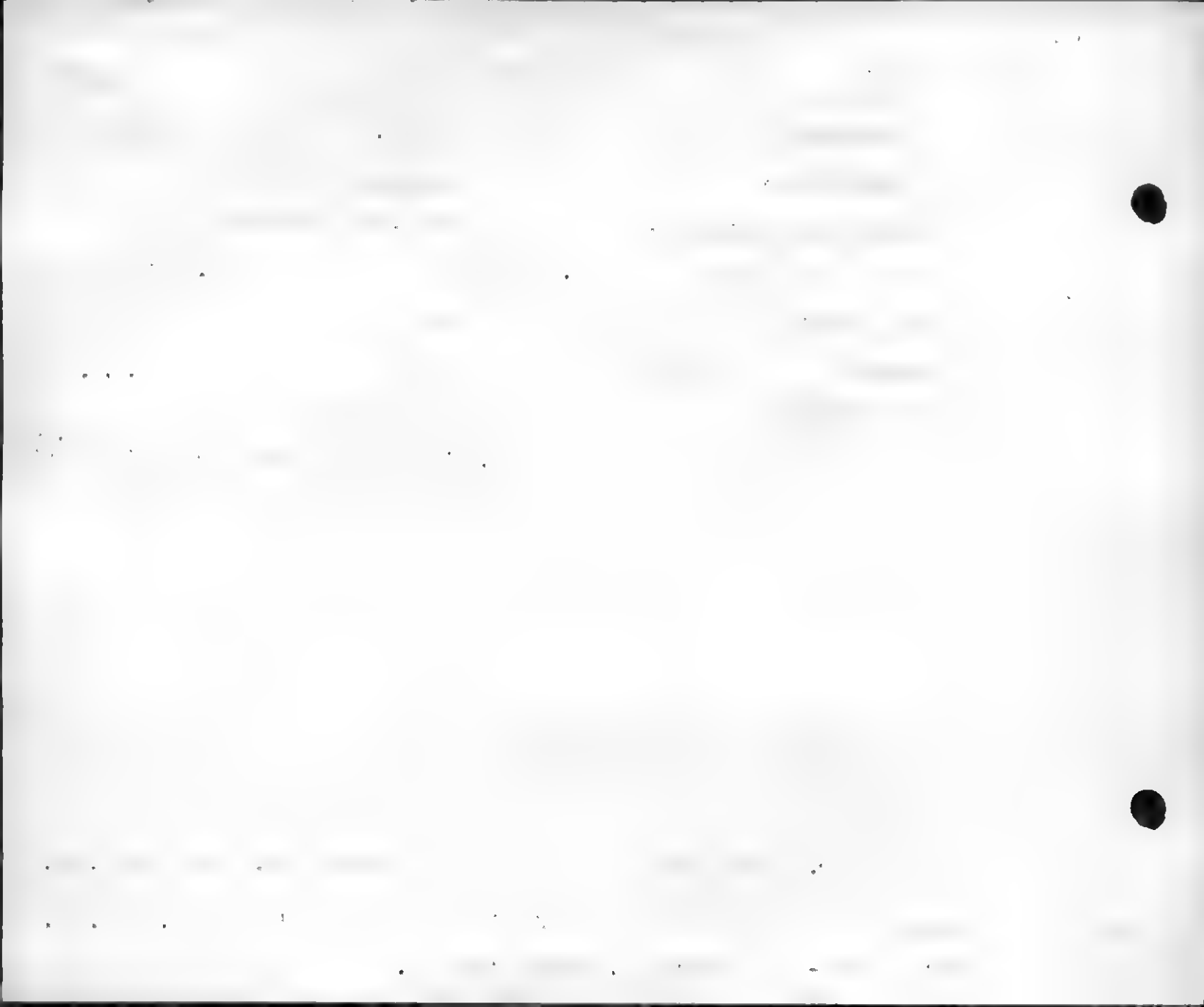
01981

01929

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Randallstown</b>		c. LENGTH OF STAY IN b. <b>Baltimore 21207</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Chapel Hill Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>Rose</b> Middle <b>P.</b> Last <b>LoVecchie</b>		4 DATE OF DEATH Month <b>Feb.</b> Day <b>20</b> Year <b>1966</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/19/1902</b>
9. AGE (In years last birthday) <b>63</b> yrs		10. IF UNDER 1 YEAR Months <b>63</b> Days <b>63</b> Hours <b>63</b> Min. <b>63</b>	11. IF UNDER 24 HRS Months <b>63</b> Days <b>63</b> Hours <b>63</b> Min. <b>63</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Italy</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Frank Provenzano</b>		14. MOTHER'S MAIDEN NAME <b>Rose Veneziano</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>No</b>	
17. INFORMANT <b>Mr. Michael Leo LoVecchie</b>		Address <b>Rd. -7 3601 1/2 Milford Mill</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute myocardial infarct</b> 4 <b>1</b> DUE TO <b>A.S.C.V.D.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <b>Jan</b> , 1966; to <b>2/21</b> , 1966, that (1) (we) last saw the deceased alive on <b>2/19</b> , 1966, and that death occurred at <b>10:00</b> M. from causes on and on the date stated above.			
22a. SIGNATURE <b>Dr. Morton Ellin</b>		22b. DATE SIGNED <b>2/23/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Morton Ellin</b>		22d. ADDRESS <b>8629 Liberty Rd. Randallstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>2/24/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Garden Of Faith</b>	23d. LOCATION (City or Town) (County) (State) <b>Trump's Mill Rd. Balt. Md.</b>
24. FUNERAL DIRECTOR <b>Loring Byers</b>		25a. REC'D BY REGISTRAR <b>FEB 28 1966</b>	
ADDRESS <b>8728 Liberty Rd. Randallstown, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

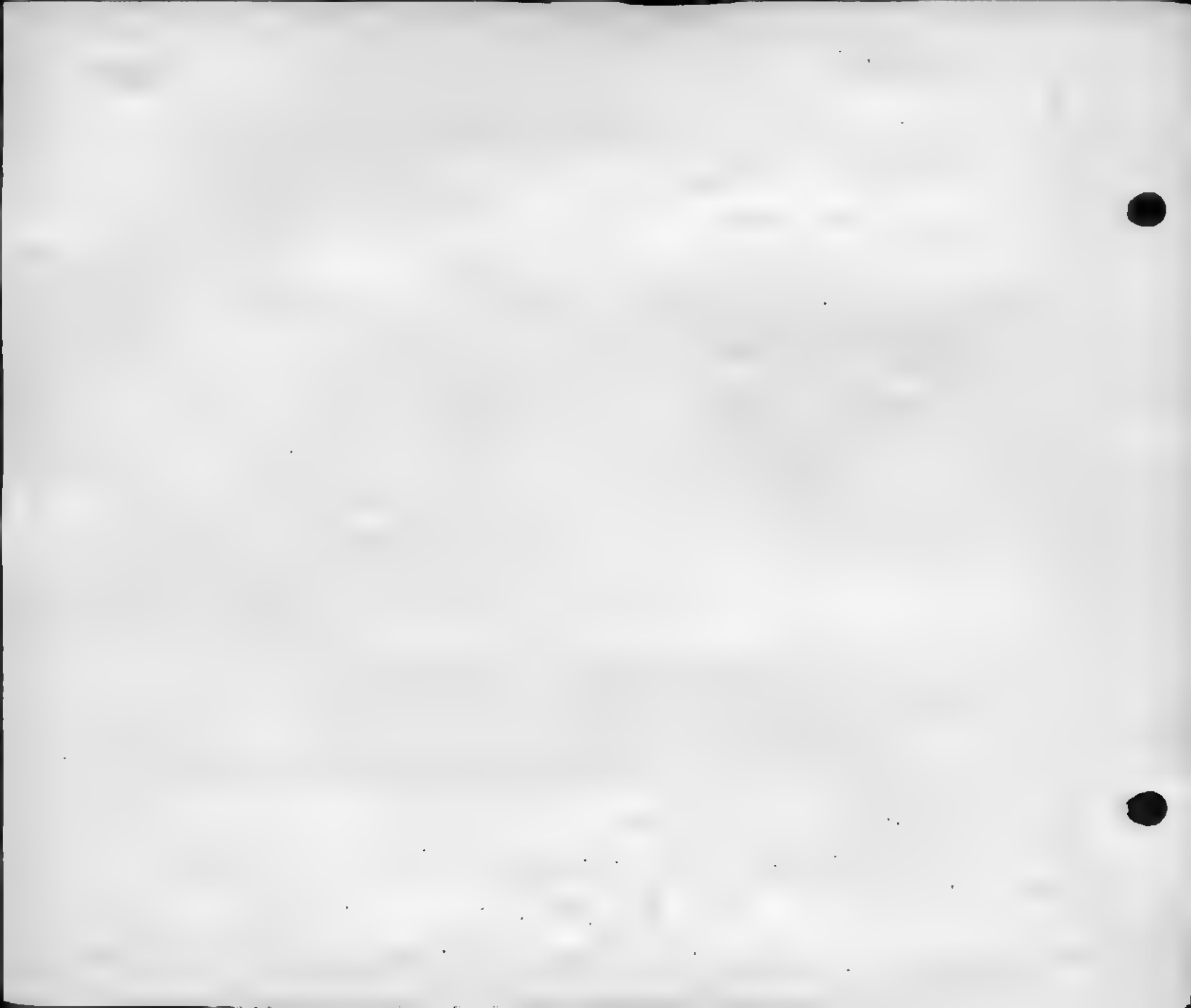
01982

01930

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>GARRISON CITY LIMIT 14R. 37 da</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>PIKEVILLE</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>FOXLEIGH NURSING HOME</u>				d. STREET ADDRESS <u>15 Sudbrook LANE.</u>			
3. NAME OF DECEASED (Type or print) <u>THOMAS</u>		First Middle Last		4. DATE OF DEATH <u>LURZ FEB 6 1966</u>		Month Day Year	
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>Wh.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN. 9 - 1874</u>	
9. AGE (In years last birthday) <u>92</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LETTER CARRIER</u>		11. BIRTHPLACE (County & State, or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Joseph LURZ</u>				14. MOTHER'S MAIDEN NAME <u>STOCKER</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>220-447939</u>		17. INFORMANT <u>MRS. HARRY REILLY</u>		Address <u>15-Sudbrook LANE #8</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>TERMINAL PNEUMONIA</u>							
DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) <u>ARTEROSCLEROTIC HEART DISEASE</u>							
DUE TO							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>e.m.</u> <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2-6-1966</u> to <u>2-6-1966</u> that (I) (we) last saw the deceased alive on <u>2-6-1966</u> , and that death occurred at <u>7:00 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Samuel P. Scaglia</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2-6-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>SAMUEL P. SCAGLIA</u>				22d. ADDRESS <u>2 SHERWOOD AVE, PIKEVILLE MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
<u>Removal</u>		<u>Feb 9 1966</u>		<u>Old Redemptor</u>		<u>Baltimore Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell</u>				25. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
ADDRESS <u>Pikeville, Md.</u>				DATE <u>FEB 11 1966</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

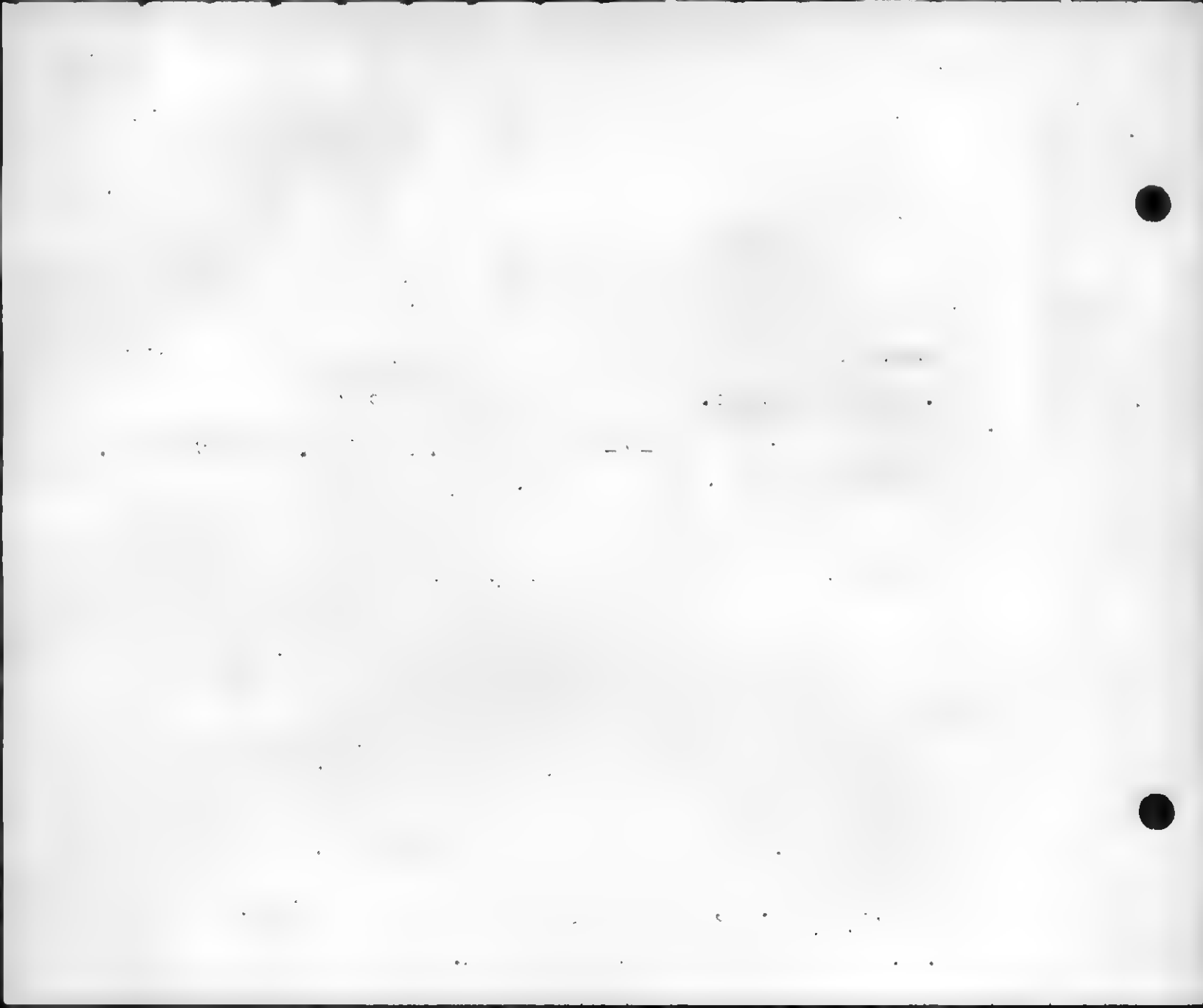


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please prepare carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
CERTIFICATE OF DEATH										
01983										
01931										
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph's Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>601 DeBaugh Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Elizabeth Irene Lyness</b> First Middle Last					4. DATE OF DEATH <b>February 9 1966</b> Month Day Year					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1-7-1922</b> yrs.		9. AGE (In years last birthday) <b>44</b> Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER</b>					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>S. CLARENCE SMITH Sr.</b>					14. MOTHER'S MAIDEN NAME <b>IRENE McNULTY</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service)					16. SOCIAL SECURITY NO. <b>214-20-4708</b>		17. INFORMANT <b>ARTHUR A. LYNESS Jr.</b> Address <b>601 DeBAUGH AVE.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Confluent lobular pneumonia, left.</b> DUE TO (b) <b>Status 5 years post-mastectomy for carcinoma of right breast.</b> DUE TO (c) <b>Metastasis to thyroid, neck muscles and vertebrae.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										
INTERVAL BETWEEN ONSET AND DEATH										
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <b>February 1, 1966</b> to <b>February 9, 1966</b> , that (I) (we) last saw the deceased alive on <b>February 9, 1966</b> , and that death occurred at <b>6:10 PM</b> from the causes and on the date stated above.										
22a. SIGNATURE <b>D.R. Govinda Roa</b>					22b. DATE SIGNED <b>February 10, 1966</b>					
22c. PHYSICIAN'S NAME (Type) <b>D. R. Govinda Roa, M.D.</b>					22d. ADDRESS <b>7620 York Rd., Towson, Md. 21204</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>FEB. 12, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MOUNT MARIA CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>TOWSON, MARYLAND</b>				
24. FUNERAL DIRECTOR <b>J. E. LOWELL LEMMON</b> ADDRESS <b>4611 PARK HEIGHTS AVE.</b>					25a. REC'D BY REGISTRAR <b>FEB 14 1966</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					







# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01985

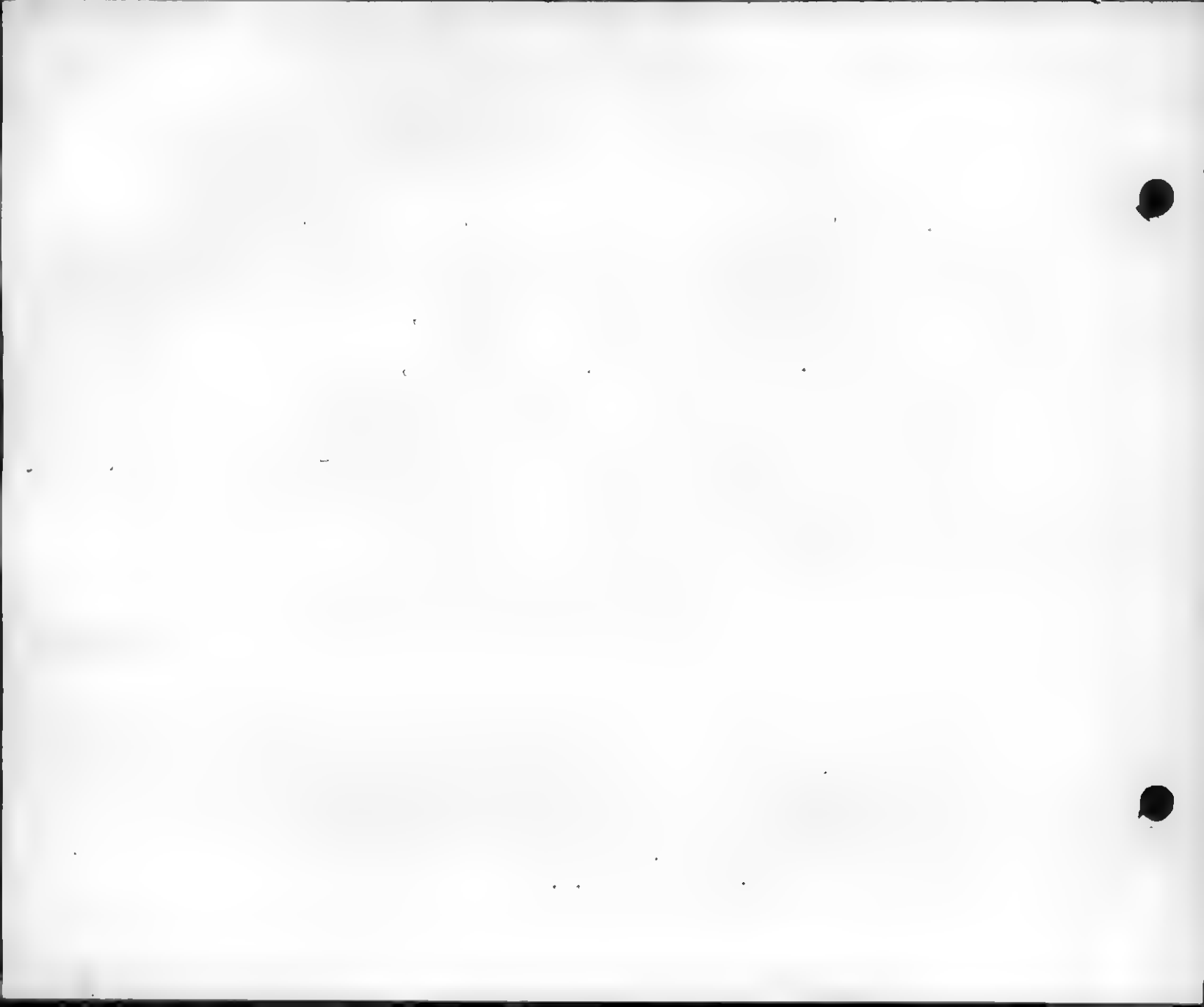
01933

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY <b>Baltimore</b> b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> c LENGTH OF STAY IN 1b <b>03-1</b> d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>St. Joseph's Hospital</b>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Perry Hall</b> c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d STREET ADDRESS <b>9806 Gunforge Rd., Perry Hall</b> e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>Joseph Maggio</b>		4 DATE OF DEATH Month Day Year <b>February 7, 1966</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>March 5, 1876</b>
9 AGE (In years last birthday) <b>89 yrs</b>		10 IF UNDER 1 YEAR Months Days Hours Min <b>- 26</b>	11 IF UNDER 24 HRS Hours Min <b>1045</b>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Self Emp.</b>		10b KIND OF BUSINESS OR INDUSTRY <b>Restaurant owner</b>	
11 BIRTHPLACE (State or foreign country) <b>Sicily, Italy</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>Salvatore Maggio</b>		14 MOTHER'S MAIDEN NAME <b>Rose Fazio</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <b>Never</b>		16 SOCIAL SECURITY NO <b>215-50-2616</b>	
17 INFORMANT <b>Angeline Maggio</b>		Address <b>9806 Gunforge Rd. Perry H.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO <b>Arteriosclerotic Corda Renal</b> DUE TO <b>Vascular Disease</b> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>1045</b>	
19a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles F. O'Donnell, M.D.</b> EXAMINER'S NAME (Type)		22. DATE SIGNED <b>2/7/66</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b DATE THEREOF <b>2-11-66</b>	23c NAME OF CEMETERY OR CREMATORY <b>HOLY REDEMPTION</b>	23d LOCATION (City or town) (County) (State) <b>Balto MD</b>
24 FUNERAL DIRECTOR <b>C. F. EVANS &amp; SON</b> ADDRESS <b>8802 NANTUCKET RD</b>		25a REC'D BY REGISTRAR DATE <b>FEB 11 1966</b> 25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

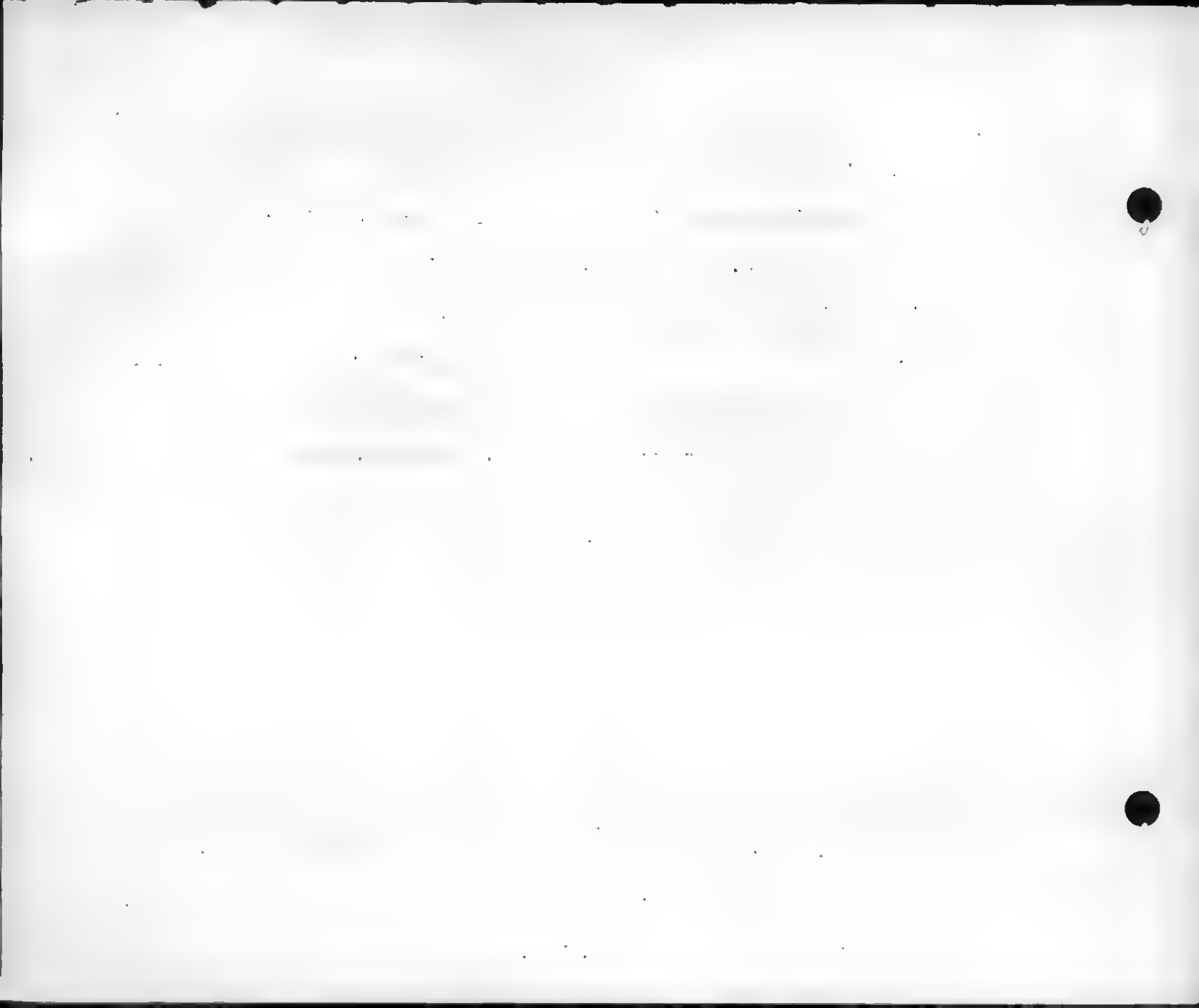
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01986

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

01334

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>ARBUTUS</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>5532 CARVILLE AVENUE 21227</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>ARBUTUS</b> d. STREET ADDRESS <b>5532 CARVILLE AVENUE 21227</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>J. SHERWOOD MANGOLD</b>		4. DATE OF DEATH Month <b>2</b> Day <b>21</b> Year <b>1966</b>					
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/3/07</b>	9. AGE (in years last birthday) <b>58</b> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ACCOUNTANT</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>			
13. FATHER'S NAME <b>WILLIAM MANGOLD</b>		14. MOTHER'S MAIDEN NAME <b>LENA STREIT</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>-----</b>		17. INFORMANT <b>MRS. DOROTHY B. MANGOLD, 5532 CARVILLE AVE.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Mitotic Carcinoma Brain</b> <b>163X</b> DUE TO (b) <b>Carcinoma Lung</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					INTERVAL BETWEEN ONSET AND DEATH <b>4 mo</b> <b>4 mo</b>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that (i) (this hospital) attended the deceased from <b>Oct 10, 1965</b> , to <b>Feb 21, 1966</b> , that (ii) (we) last saw the deceased alive on <b>Feb 20, 1966</b> , and that death occurred at <b>11:58 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>A. Bradley Daugharthy</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>A. BRADLEY DAUGHARTHY</b>		22d. ADDRESS <b>1264 FRANCIS AVENUE 21227</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>2/25/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>LOUDON PARK CEMETERY</b>	23d. LOCATION (City, town or county) (State) <b>BALTIMORE, MARYLAND</b>				
24. FUNERAL DIRECTOR <b>HUBBARD FUNERAL HOME, 4107 WILKENS AVENUE 21229</b>		25a. REC'D BY REGISTRAR <b>FEB 24 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

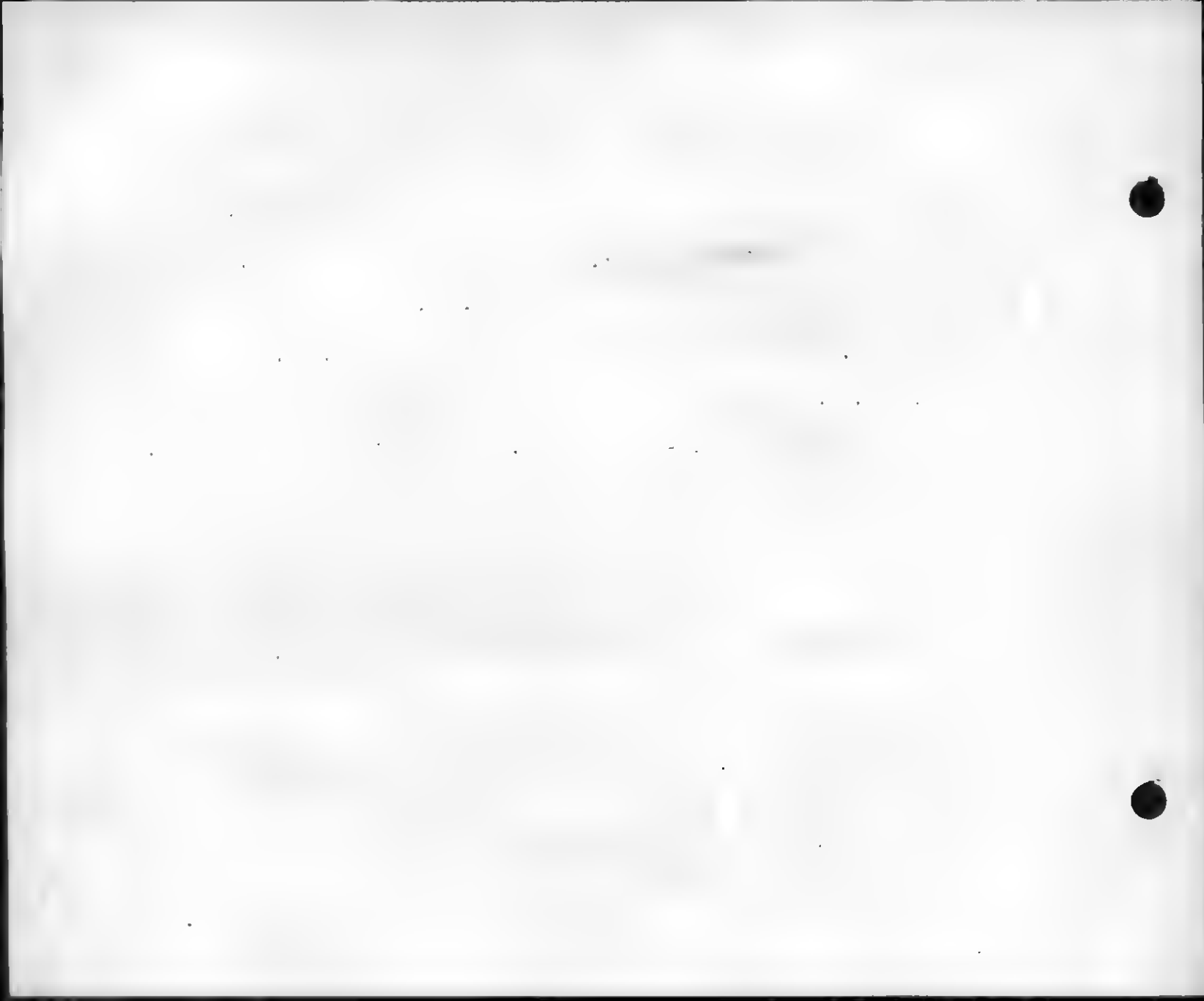
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

01987

01935

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>CATON RIDGE NURSING HOME</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>3901 Greenmount Ave. 18</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>															
3. NAME OF DECEASED (Type or print) <b>Daisy M. Marriott</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>20</b> Year <b>19 66</b>		5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 23, 1882</b>		9. AGE (In years last birthday) <b>83</b> yrs.		10. IF UNDER 1 YEAR, IF UNDER 24 HRS. Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dental Asst. - Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b></b>				11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Md.</b>				12. CITIZEN OF WHAT COUNTRY? <b></b>							
13. FATHER'S NAME <b>George H. M. Marriott</b>				14. MOTHER'S MAIDEN NAME <b>Mary Jane Grim</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>215-05-0243</b>				17. INFORMANT <b>Mr. Frederick Failey</b> <b>115 Central Ave. Glynden, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> 161 DUE TO (b) <b>Uremia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>Nephrosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized Arteriosclerosis</b>												INTERVAL BETWEEN ONSET AND DEATH <b></b>							
												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
												20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b></b>				20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b></b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>				20f. (City or town) (County) (State) <b></b>			
21. I certify that (I) (this hospital) attended the deceased from <b>1-14-</b> , 19 <b>65</b> , to <b>2-19-</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>2-19-</b> , 19 <b>66</b> , and that death occurred at <b>12:30</b> M, from the causes and on the date stated above.																			
22a. SIGNATURE <b>Cesar Valle Cervero</b>				M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <b>2-20-66</b>				22c. PHYSICIAN'S NAME (Type) <b>CESAR VALLE CAVERO</b>				22d. ADDRESS <b>8624 Liberty Rd</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>2/23/ 1966</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>				23d. LOCATION (City, town or county) (State) <b>Woodlawn, Md.</b>							
24. FUNERAL DIRECTOR <b>Wm. J. Schner + Son</b>				ADDRESS <b>Baltimore, Md. 17</b>				25a. REC'D BY REGISTRAR <b>FEB 23 1966</b>				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>							



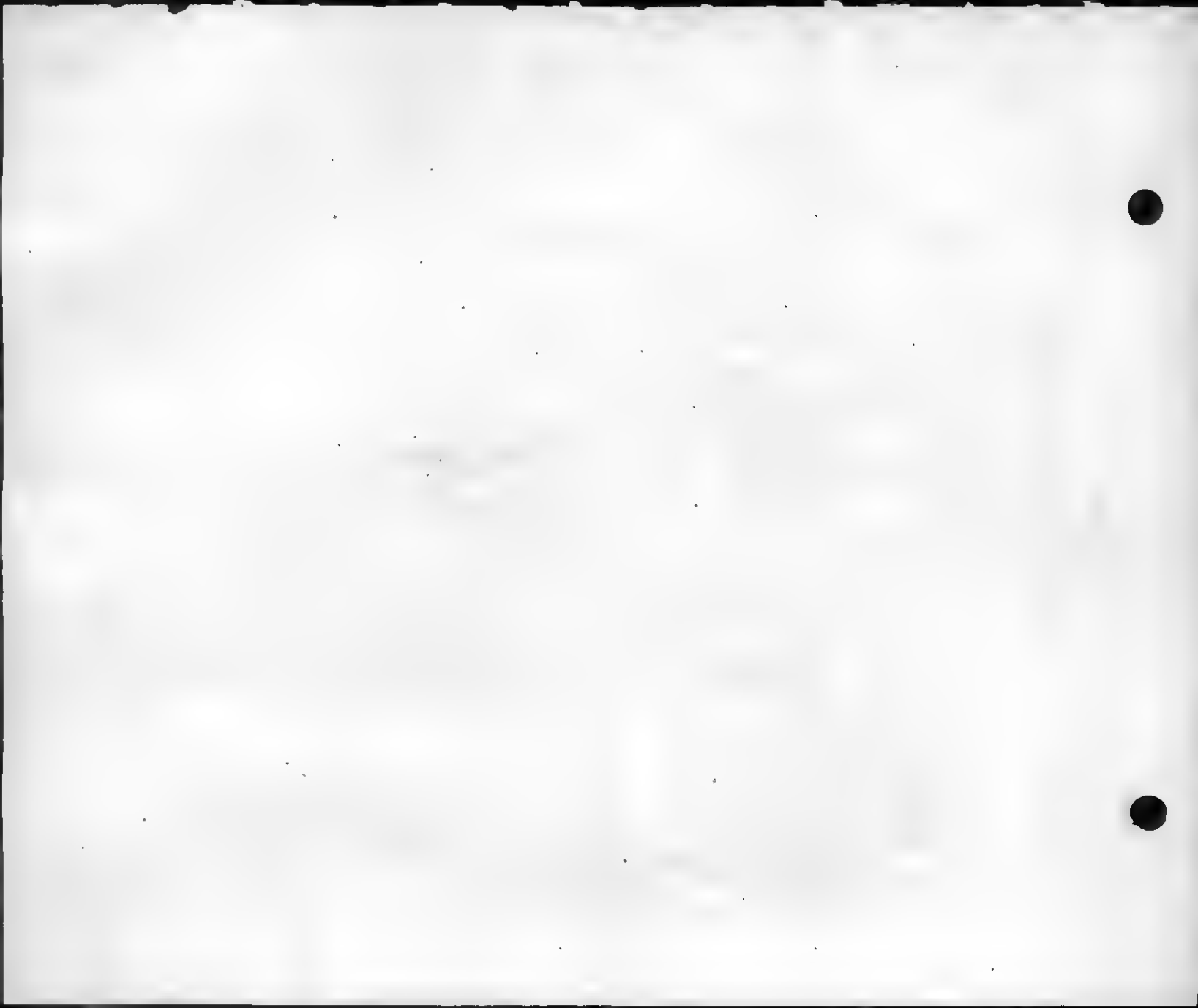
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and may event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
01988					01936				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY <b>Baltimore</b>			b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1d <b>Maryland</b>			d. STREET ADDRESS <b>910 Mace Ave.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH				
First <b>Stanley</b> Middle <b>Martin</b> Last <b>Martin</b>					Month <b>February</b> Day <b>6</b> Year <b>19 66</b>				
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-11-1887</b>		9. AGE (in years last birthday) <b>78</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>New York Brooklyn Navy Yard</b>		11. BIRTHPLACE (County & State, or foreign country) <b>78 Ohio</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>Michael Glowacki</b>					14. MOTHER'S MAIDEN NAME <b>2</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16. SOCIAL SECURITY NO. <b>212-01-19268</b>				
					17. INFORMANT <b>Southy Bailewskas 118 N. Dp. Ave. A. r.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>arteriosclerotic heart disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____									INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>Feb. 2</b> , 19 <b>66</b> , to <b>Feb. 6</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>Feb. 6</b> , 19 <b>66</b> , and that death occurred at <b>5:15 p.m.</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>Teodoro A. Carangal</b>					22b. DATE SIGNED <b>Feb. 6 1966</b>				
22c. PHYSICIAN'S NAME (Type) <b>TEODORO CARANGAL M.D.</b>					22d. ADDRESS <b>7620 York Rd. Baltimore, Md. 21204</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>2/9/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Balto. Md.</b>			
24. FUNERAL DIRECTOR <b>Connelly 300 Mace Ave.</b>					25a. REC'D BY REGISTRAR <b>Feb 9 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

MEDICAL CERTIFICATION



TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

01989

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

01037

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Carney</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Carney</u>			
c. LENGTH OF STAY IN ID <u>25 yrs</u>				d. STREET ADDRESS <u>2407 E. Joppa Road</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>2407 E. Joppa Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Augusta</u> Middle <u>Marx</u> Last <u>Marx</u>			4. DATE OF DEATH Month <u>2</u> Day <u>14</u> Year <u>1966</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-19-1872</u>	9. AGE (in years last birthday) <u>93 yrs.</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>7</u> Days <u>14</u> Hours <u>19</u> Min. <u>66</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wilhelm Kempske</u>				14. MOTHER'S MAIDEN NAME <u>Amelia Ernst</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs Gary Jermain 2407 E. Joppa Road</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial degeneration.</u> 1221 DUE TO <u>Generalized Atherosclerotic Cardiovasc Dis</u> (b) <u>General debilitation</u> DUE TO <u>General debilitation</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebro Vascular Insufficiency</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 yr.</u> <u>15 yr.</u>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (i) (this hospital) attended the deceased from <u>Aug</u> , 19 <u>64</u> , to <u>Feb</u> , 19 <u>66</u> , that (ii) (we) last saw the deceased alive on <u>Jan 7</u> , 19 <u>66</u> , and that death occurred at <u>2 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>				22b. DATE SIGNED <u>2/15/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>FT KASIK</u>				22d. ADDRESS <u>9005 Harford Rd</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-16-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Jerusalem Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore Md.</u>	
24. FUNERAL DIRECTOR <u>Lassahn Funeral Home 7401 Belair Road</u>				25a. REC'D BY REGISTRAR <u>36</u> DATE <u>FEB 16 1966</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

*[Faint, illegible handwritten text, possibly bleed-through from the reverse side of the page. The text is mirrored and difficult to decipher.]*

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

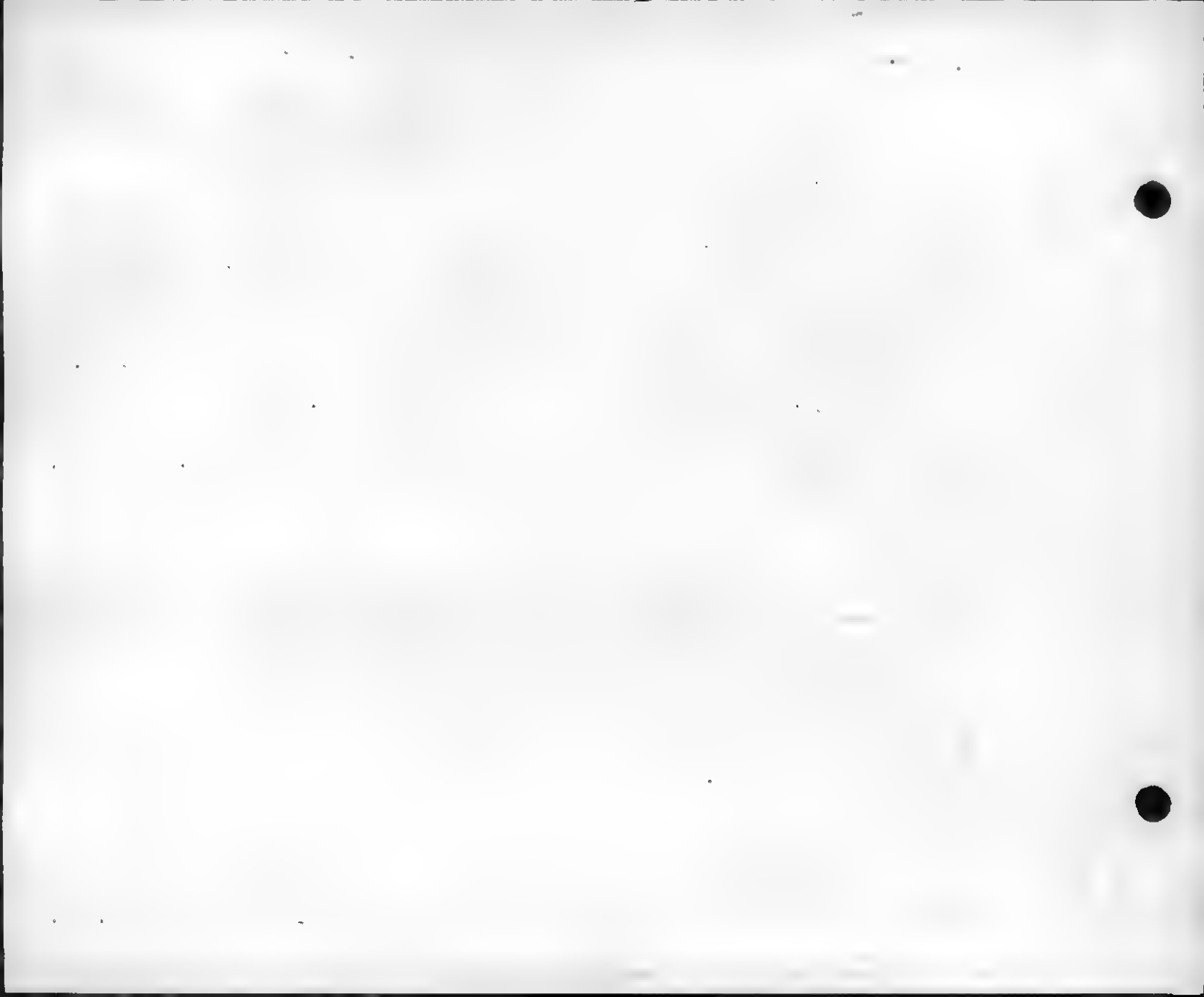
## CERTIFICATE OF DEATH

01938

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>19 hrs 20 min</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hampstead</b>		d. STREET ADDRESS <b>Millers Station Road, RFD 2</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JAMES THOMAS MATHEWS</b>		4. DATE OF DEATH Month <b>February</b> Day <b>24</b> Year <b>19 66</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. AGE (In years last birthday) <b>33</b>		9. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>		11. KIND OF BUSINESS OR INDUSTRY <b>Automobile</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Fulton A. Mathews</b>		14. MOTHER'S MAIDEN NAME <b>Evelyn C. Atkinsons</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO <b>PL-28 213-30-03-37</b>		17. INFORMANT <b>Clinical Rcds, VA Hospital, Ft. Howard, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> DUE TO <b>PULMONARY EDEMA</b> DUE TO: <b>PULMONARY INFARCTION</b> DUE TO <b>MULTIPLE SCLEROSIS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b> <b>RECENT</b> <b>RECENT</b> <b>9 YEARS</b>		PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)		21. I certify that (X) (this hospital) attended the deceased from <b>2/23/66</b> , 19 <b>66</b> , that (X) (we) last saw the deceased alive on <b>Feb. 24</b> , 19 <b>66</b> , and that death occurred at <b>5:30</b> M, from causes and on the date stated above.			
22a. SIGNATURE <i>Lawrence F. Awalt, Jr.</i>		22b. DATE SIGNED <b>2/25/66</b>		22c. PHYSICIAN'S NAME (Type) <b>LAWRENCE F. AWALT, JR., M. D.</b>		22d. ADDRESS <b>VA Hospital, Fort Howard, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>2-28-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LAKEVIEW MEMORIAL CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>LIBERTY RD. BALTO. MD.</b>			
24. FUNERAL DIRECTOR <b>Tipton Eline Funeral</b>		25a. REC'D BY REGISTRAR <b>HAR 1 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

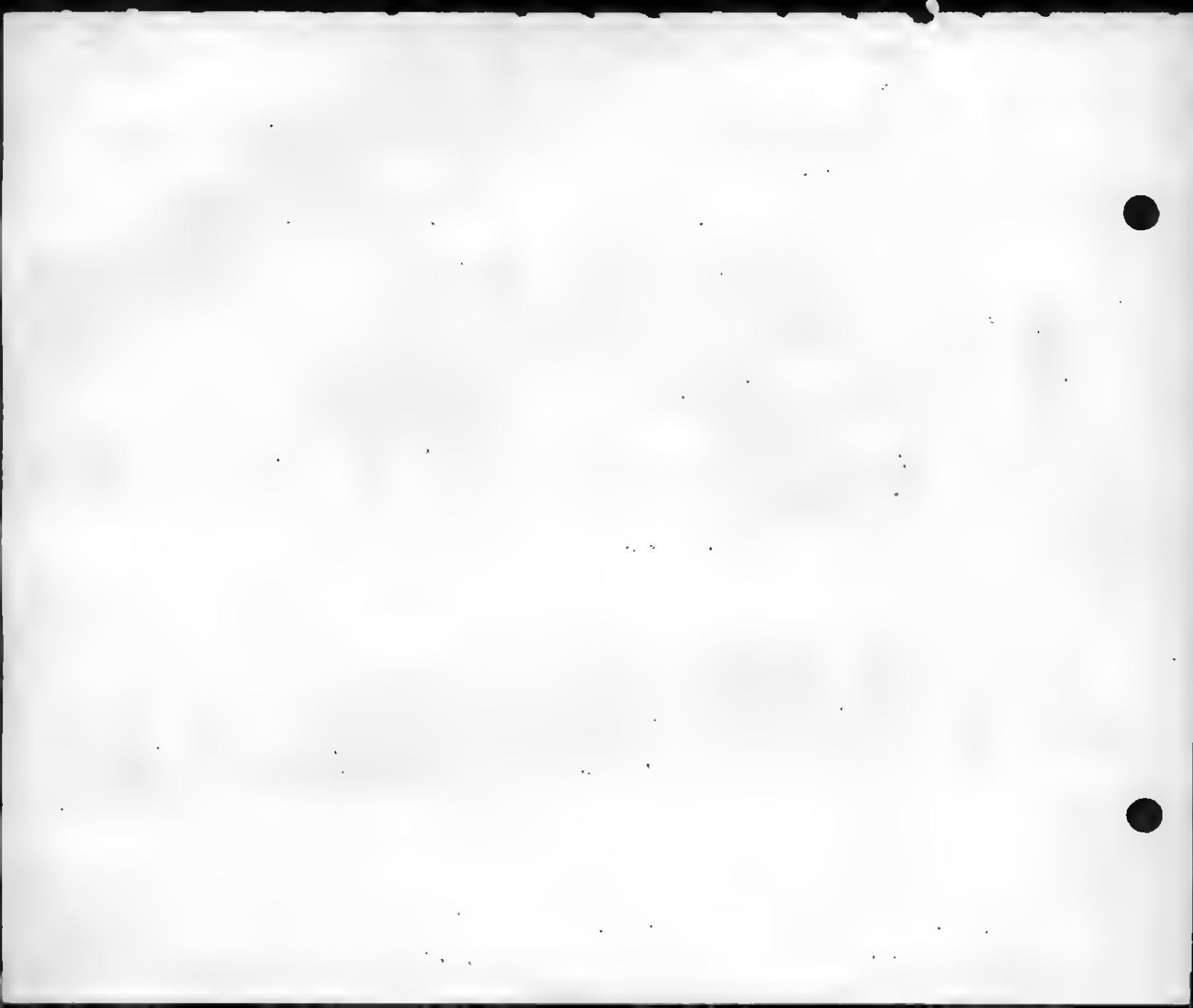
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.



0' 939

23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE HEREOF 2/15/66	23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem.	23d. LOCATION (City, town or county) (State) Pikesville Md.
24. FUNERAL DIRECTOR Frank H. Newell		ADDRESS Pikesville 8 Md.	25a. REC'D BY REGISTRAR DATE FEB 15 1966
			25b. REGISTRAR'S SIGNATURE Charles Judge

VR A15 (4)  
20M 1/65



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

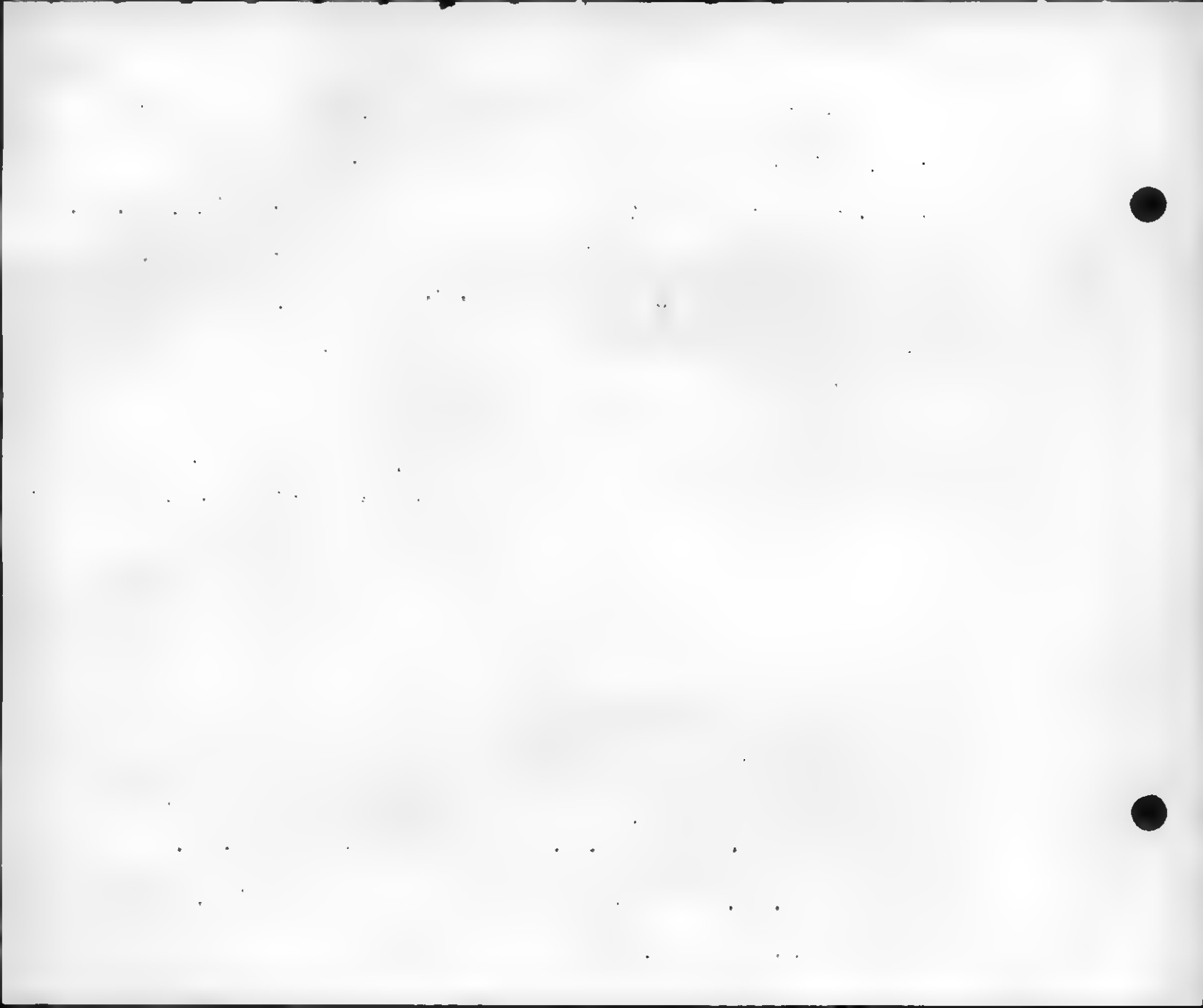
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MEDICAL CERTIFICATION

M											
1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Brooklandville</i>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Brooklandville</i>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Falls Road near Valley Road</i>						d. STREET ADDRESS <i>Falls Road Near V' lley Rd.</i>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Ellen Mottugh McAffrey</i>			First Middle Last			4. DATE OF DEATH Month <i>February</i> Day <i>24</i> Year <i>1966</i>			5. SEX <i>Female</i>		
6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Nov. 1, 1890</i>		9. AGE (In years last birthday) <i>75</i> yrs.		IF UNDER 1 YEAR Months Days Hours Mln.		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Pennsylvania</i>			12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>John McMaris</i>						14. MOTHER'S MAIDEN NAME <i>Jane Ann Todd</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Family Records</i>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Gall Bladder</i> DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <i>3 mos.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <i>Oct 15, 1962</i> to <i>Feb 24, 1966</i> that (I) (we) last saw the deceased alive on <i>Feb 23, 1966</i> and that death occurred at <i>8 P.M.</i> from the causes and on the date stated above.											
22a. SIGNATURE <i>George T. Gilmore</i>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <i>George T. Gilmore, M. D.</i>						22d. ADDRESS <i>Lutherville, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Feb. 27, 1966</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Jessops Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Cockeysville, Maryland</i>					
24. FUNERAL DIRECTOR <i>John Burns' Sons, Towson, Maryland</i>						25a. REC'D BY REGISTRAR DATE <i>MAR 2 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

1072



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please take the carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01993 02941

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mount Wilson</b> c. LENGTH OF STAY IN 1b <b>9 1/2 mo.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Mount Wilson State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b> d. STREET ADDRESS  e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>WILLIAM IRVIN McCLANAHAN</b> First Middle Last 4. DATE OF DEATH Month <b>2</b> Day <b>28</b> Year <b>1966</b>		5. SEX <b>M</b> 6. COLOR OR RACE <b>W</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>6.17.1921</b> 44 yrs. 9. AGE (In years last birthday) <b>44</b> 10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chauffeur</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>Virginia</b> 11. BIRTHPLACE (County & State, or foreign country) <b>USA</b> 12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>LUTHER T. McCLANAHAN</b> 14. MOTHER'S MAIDEN NAME <b>EMMA DEAVERS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> 16. SOCIAL SECURITY NO. <b>214-16-5722</b> 17. INFORMANT <b>Hosp. records</b> Address <b>Mt. Wilson State Hospital</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Far advanced pulmonary tuberculosis</b> DUE TO (b) <b>24 years</b> DUE TO (c) <b>24 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>e.m.</b> <b>19</b> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>5.6.1965</b> to <b>2.28.1966</b> , that (I) (we) last saw the deceased alive on <b>2.28.1966</b> , and that death occurred at <b>4:50</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Wm. Newcomer</b>		22b. DATE SIGNED <b>2.25.1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Wm. Newcomer, M.D., Superintendent</b>		22d. ADDRESS <b>Mount Wilson, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>3-3-1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>ST. JOHN'S</b>		23d. LOCATION (City, town or county) (State) <b>ELICOTT CITY MD</b>	
24. FUNERAL DIRECTOR <b>F.C. Higginbotham</b>		25a. REC'D BY REGISTRAR <b>MAR 2 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

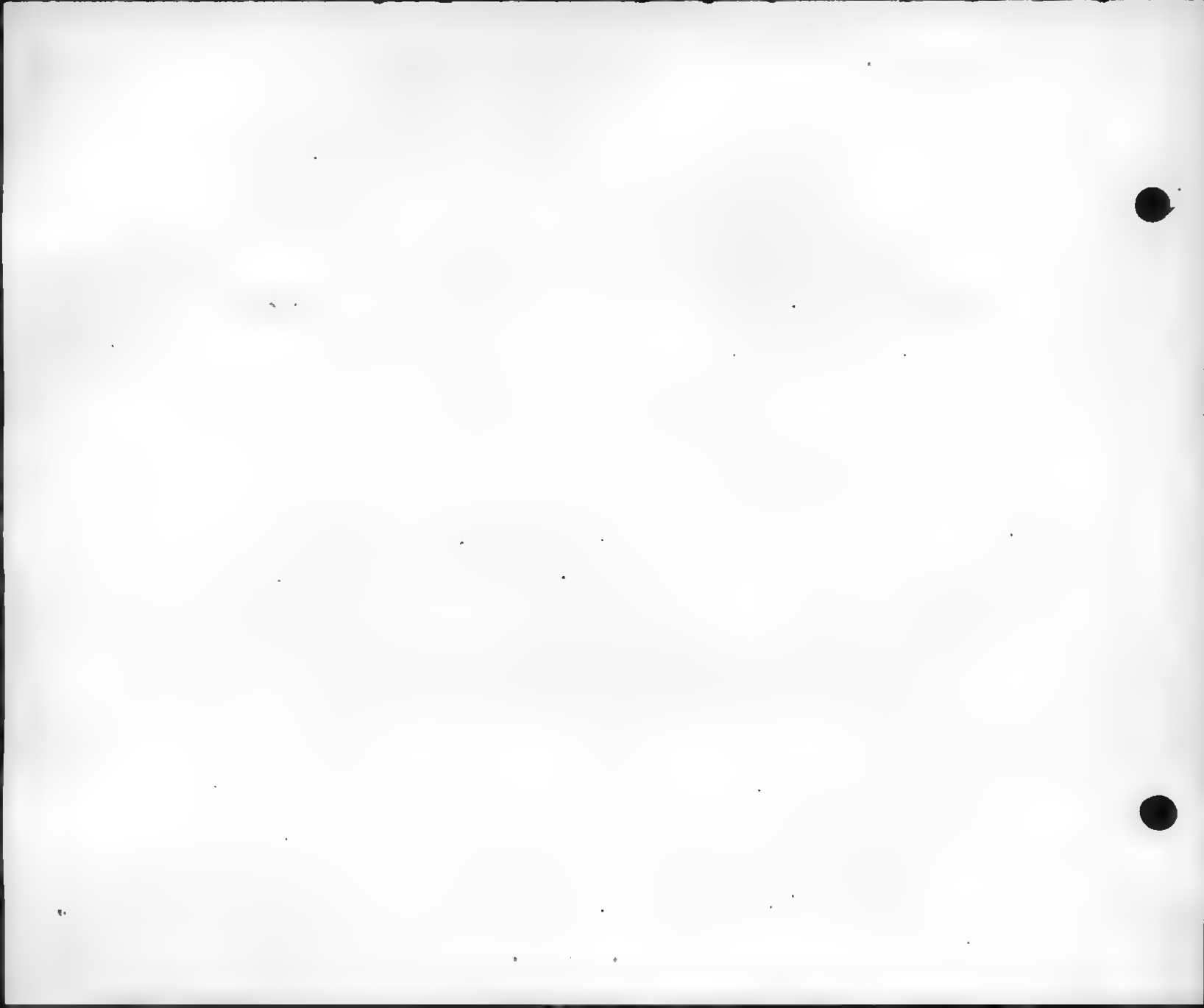


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater BALTIMORE Medical Center</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> d. STREET ADDRESS <u>3601 Greenway</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>William Wallace McCormick</u>			4. DATE OF DEATH <u>2/21/66</u>			5. SEX <u>Male</u>			6. COLOR OR RACE <u>CAUC.</u>		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>3-4-1889</u>			9. AGE (In years last birthday) <u>76</u> yrs.			10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED - REAL ESTATE - INVESTMENT</u>						10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE, Md.</u>		
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>						13. FATHER'S NAME <u>MICHAEL F. MCCORMICK</u>					
14. MOTHER'S MAIDEN NAME <u>ELEANOR SAVILLE</u>						15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>					
16. SOCIAL SECURITY NO. <u>212-14-9245</u>						17. INFORMANT <u>CHART</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>blocked kidney left</u> DUE TO (c) <u>CA blocked &amp; CA prostate</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>											
INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from <u>Feb 7</u> , 19 <u>66</u> , to <u>Feb 21</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Feb 21</u> , 19 <u>66</u> , and that death occurred at <u>1:40</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>John A. C. C. C. C.</u>				22b. DATE SIGNED <u>2-21-66</u>				22c. PHYSICIAN'S NAME (Type) <u>John A. C. C. C. C. - M.D.</u>			
22d. ADDRESS <u>3414 St. Paul St.</u>				23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>							
23b. DATE THEREOF <u>2/22/1966</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Greenmount</u>				23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>			
24. FUNERAL DIRECTOR <u>H.W. Jenkins &amp; Sons Co.</u>				25a. REC'D BY REGISTRAR <u>4905 York Road Balto. 12, Md.</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
DATE <u>FEB 23 1966</u>											



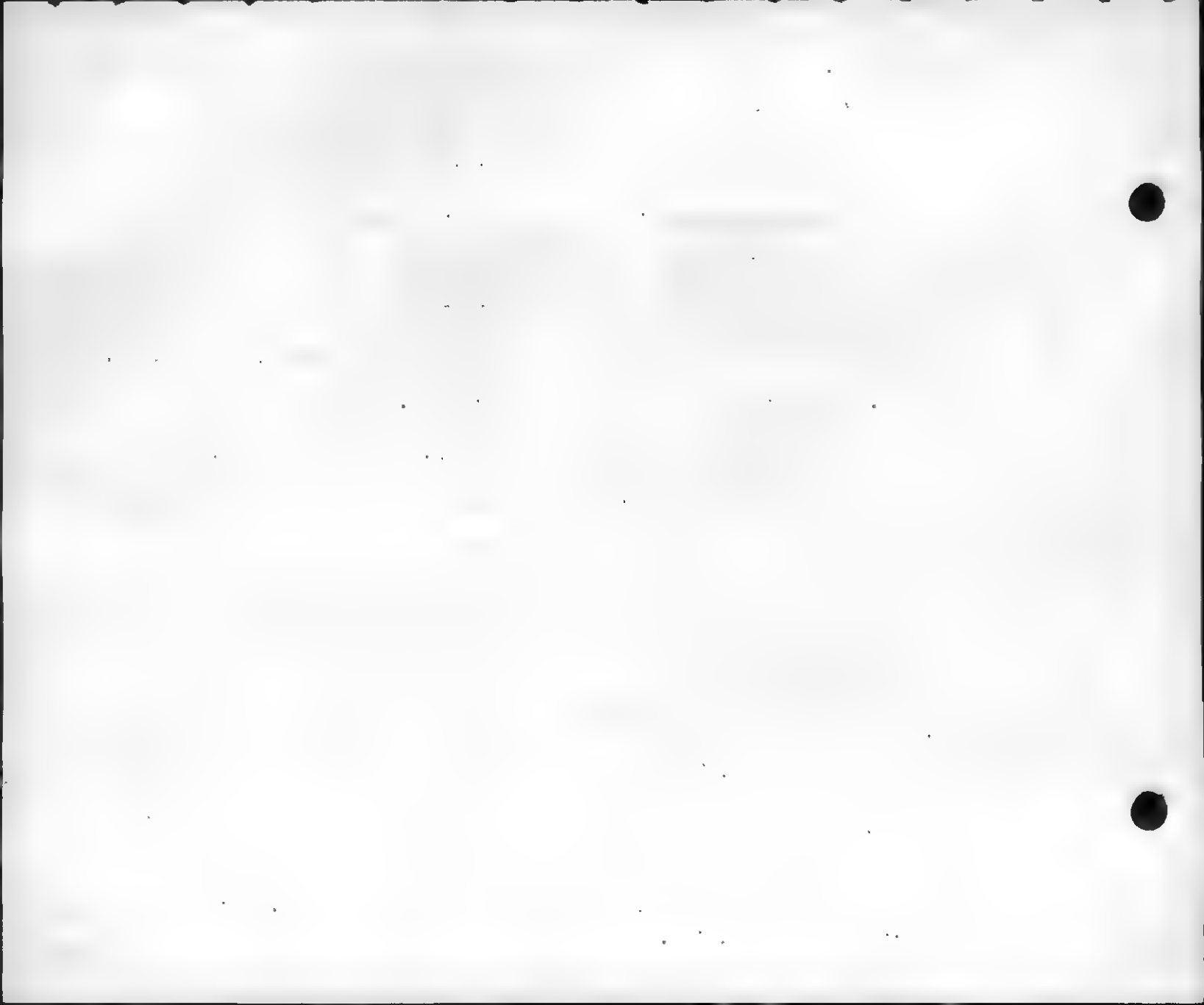
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
01995 CERTIFICATE OF DEATH 01943

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>St. Joseph Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore 21213</b> d. STREET ADDRESS <b>1719 Rutland Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Elizabeth</b> Last <b>McCubbin</b>		4. DATE OF DEATH Month <b>2</b> Day <b>4</b> Year <b>19 66</b>	
5. SEX <b>Female</b>	6. COLOR OF RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-29-1898</b> 9. AGE (In years last birthday) <b>67</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry R. Breuning</b>		14. MOTHER'S MAIDEN NAME <b>Mary E. Lyons</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b> 17. INFORMANT <b>John J. McCubbin, husband, above</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary artery disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1/27/1966</b> , to <b>2/4/1966</b> , that (I) (we) last saw the deceased alive on <b>2/4/1966</b> , and that death occurred at <b>1:40 P.</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Reynaldo P. Madrinan</b> 22c. PHYSICIAN'S NAME (Type) <b>Reynaldo P. Madrinan</b>		22b. DATE SIGNED <b>2/4/66</b> 22d. ADDRESS <b>7620 York Rd., Baltimore, Md. 21204</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/8/1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Balto., Md.</b>	
24. FUNERAL DIRECTOR <b>Schumnek Funeral Home, Inc.</b> <b>3331 Brehms Lane #13</b>		25a. REC'D BY REGISTRAR <b>FEB 7 1966</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

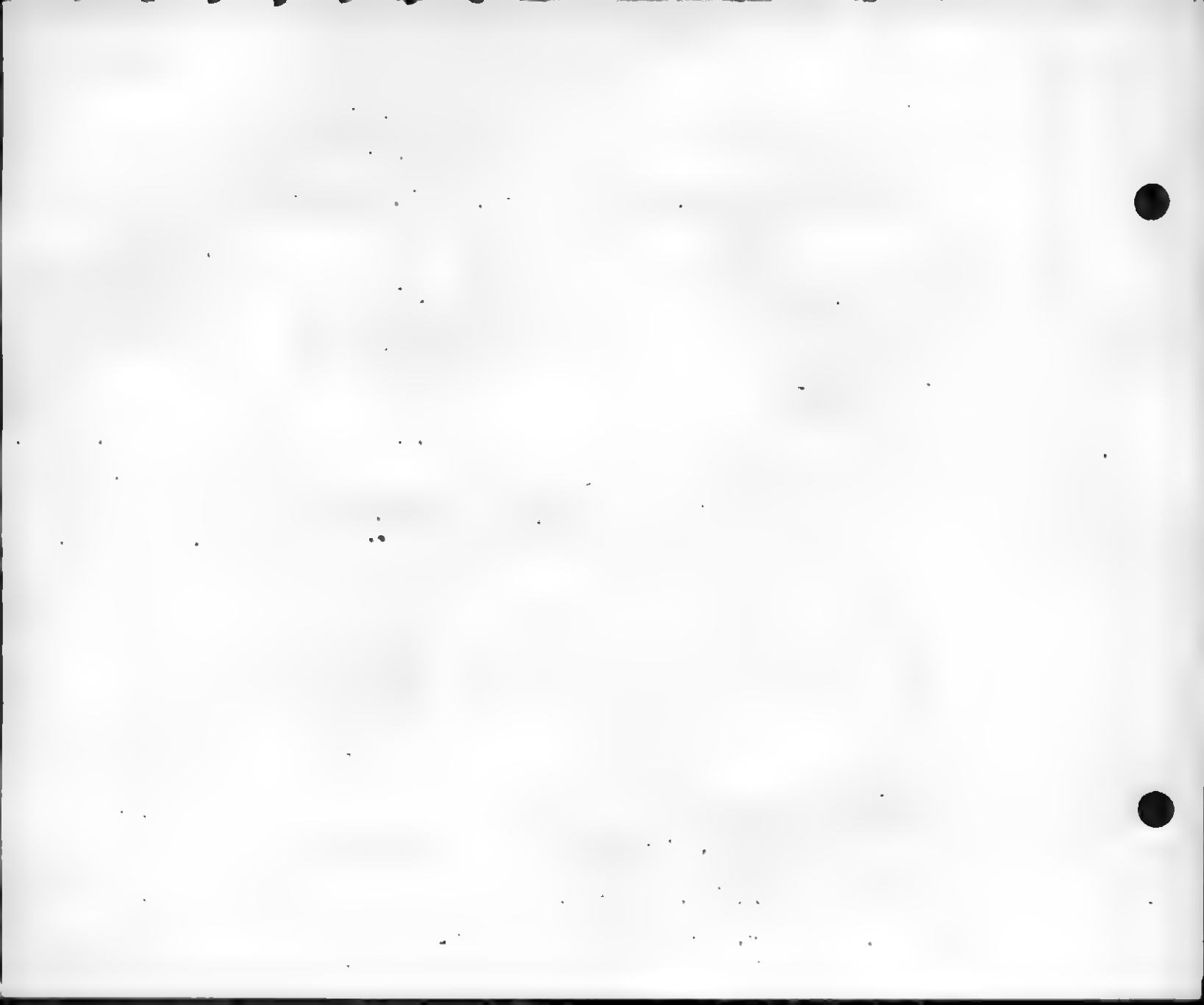


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>									
<b>01996</b>					<b>01944</b>				
<b>1. PLACE OF DEATH</b> <b>a. COUNTY</b> <u>Baltimore</u> <b>MARYLAND</b>					<b>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</b> <b>a. STATE</b> <u>Maryland</u> <b>b. COUNTY</b> <u>Baltimore</u>				
<b>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)</b> <u>RURAL, Baltimore City</u>					<b>c. LENGTH OF STAY IN 1b</b> <u>10 years</u>				
<b>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)</b> <u>Armcast Nursing Home, 812 Register Ave.</u>					<b>d. STREET ADDRESS</b> <u>755 E. 36th Street</u>				
<b>3. NAME OF DECEASED (Type or print)</b> <b>First</b> <u>BERTHA</u> <b>Middle</b> <u>MAY</u> <b>Last</b> <u>MCGARRY</u>					<b>4. DATE OF DEATH</b> <b>Month</b> <u>Feb.</u> <b>Day</b> <u>10</u> <b>Year</b> <u>19 66</u>				
<b>5. SEX</b> <u>female</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>May 12, 1884</u>		<b>9. AGE (In years last birthday)</b> <u>81</u> yrs.	
<b>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b> <u>housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> 		<b>11. BIRTHPLACE (County &amp; State, or foreign country)</b> <u>Sunman, Indiana</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>		<b>e. IS RESIDENCE ON A FARM?</b> <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>	
<b>13. FATHER'S NAME</b> <u>Herman Dreyer</u>					<b>14. MOTHER'S MAIDEN NAME</b> <u>Eliza</u>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)</b> <u>no</u>					<b>16. SOCIAL SECURITY NO.</b> 				
<b>17. INFORMANT</b> <u>John W. McGarry</u>					<b>Address</b> <u>769 McKewin Ave., Balto.</u>				
<b>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</b> <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <u>Cerebral Hemorrhage</u> <b>DUE TO</b> <u>Arteriosclerosis</u> <b>(b)</b> <u>Cardiac Renal Vasculature</u> <b>DUE TO</b> <u>underlying cause last.</u> <b>(c)</b>								<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>24 hrs</u>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>								<b>19. WAS AUTOPSY PERFORMED?</b> <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> <b>(If either, notify medical examiner)</b>					<b>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)</b>				
<b>20c. TIME OF INJURY</b> Month, Day, Year <b>Hour a.m.</b> <u>19</u> <b>p.m.</b>		<b>20d. INJURY OCCURRED</b> <b>While at work</b> <input type="checkbox"/> <b>Not While at work</b> <input type="checkbox"/>		<b>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</b>		<b>20f. (City or town)</b> <u>Cincinnati, Ohio</u>		<b>(County)</b> <u>Cincinnati</u> <b>(State)</b> <u>Ohio</u>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>2/11, 1966</u> <b>to</b> <u>2/10, 1966</u> <b>that (I) (we) last saw the deceased alive on</b> <u>2/10, 1966</u> <b>and that death occurred at</b> <u>3:30 P.M.</u> <b>from the causes and on the date stated above.</b>									
<b>22a. SIGNATURE</b> <u>Charles F. O'Donnell</u>					<b>22b. DATE SIGNED</b> <u>2/11/66</u>				
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Charles F. O'Donnell</u>					<b>22d. ADDRESS</b> <u>7501 York Road</u>				
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>2/14/66.</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Spring Grove</u>		<b>23d. LOCATION (City, town or county)</b> <u>Cincinnati, Ohio</u> <b>(State)</b>			
<b>24. FUNERAL DIRECTOR</b> <u>Leonard J. Ruck, Inc.</u>					<b>25a. REC'D BY REGISTRAR</b> <b>DATE</b> <u>FEB 15 1966</u>				
<b>ADDRESS</b> <u>5305 Harford Rd, Balto.</u>					<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>				



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

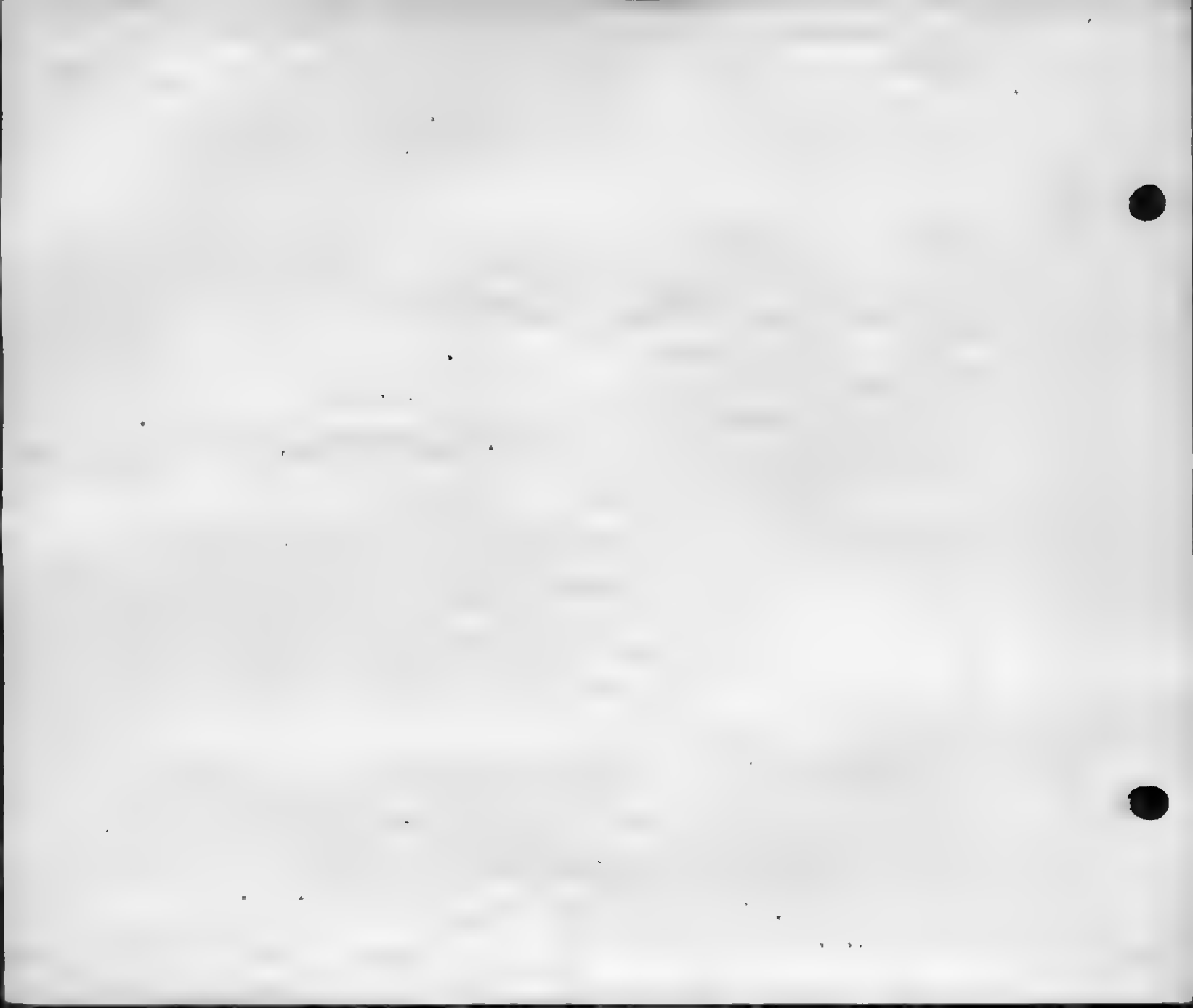
## CERTIFICATE OF DEATH

01997

01945

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Forest Haven Nursing Home</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Ma.</u> b. COUNTY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>17 N. Jackson Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Ella McGuire</u>		<b>4. DATE OF DEATH</b> Month <u>Feb.</u> Day <u>2</u> Year <u>1966</u>	
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>May 13/82</u>
<b>9. AGE</b> (In years last birthday) <u>83</u> yrs.		<b>10. IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>None</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>None</u>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>Robinson</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Unknown</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>  </u>		<b>16. SOCIAL SECURITY NO.</b> <u>  </u>	
<b>17. INFORMANT</b> <u>Mrs. Mary Fineblum, 905 Forwood Circle</u>		Address <u>Balto. 28</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic cardiac vascular disease</u> (a), stating the underlying cause last. (c) <u>Chronic renal disease</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>  </u> a.m. <u>  </u> p.m.	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State)
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>1/1/66</u> <b>to</b> <u>2/2/66</u> <b>, that (I) (we) last saw the deceased alive on</b> <u>2/2/66</u> <b>, and that death occurred at</b> <u>  </u> <b>M., from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>John D. Shaw M.D.</u>		<b>22b. DATE SIGNED</b> <u>2/4/66</u>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>John D. Shaw M.D.</u>		<b>22d. ADDRESS</b> <u>5800 Edmondson Ave. Balto. Md.</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>burial</u>	<b>23b. DATE THEREOF</b> <u>Feb. 5/66</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>New Cathedral</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Witzke F.D. 4101 Edmondson Ave</u>		<b>25a. REC'D BY REGISTRAR</b> DATE <u>FEB 7 1966</u>	
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

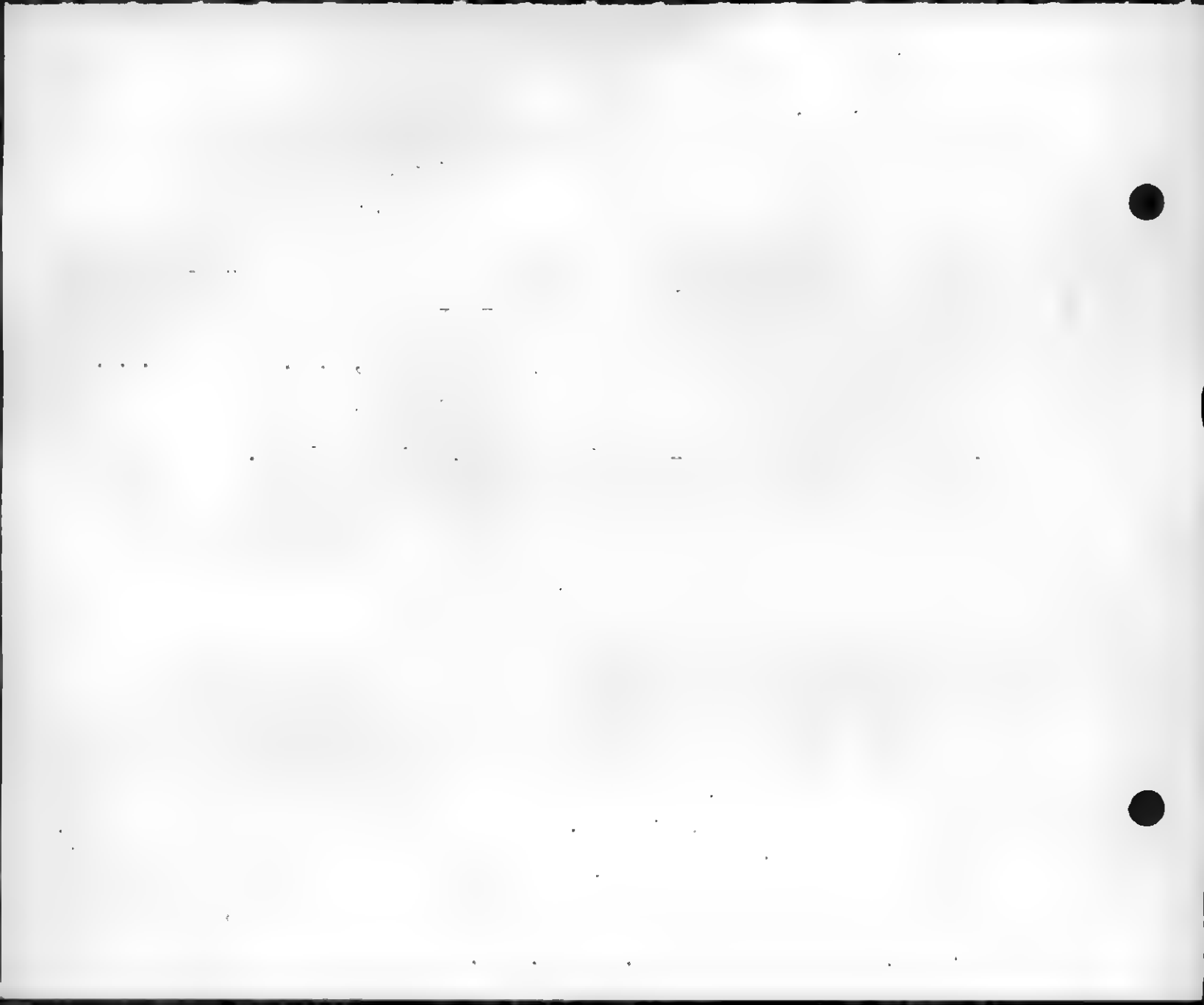
01993

01016

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sparrows Point</b>				c. LENGTH OF STAY IN ID <b>Baltimore</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Plant Dispensary</b>				e. STREET ADDRESS <b>2310 Mount Royal</b>			
3. NAME OF DECEASED (Type or print) First <b>Foster</b> Middle <b>McNeill</b> Last <b>McNeill</b>				4. DATE OF DEATH Month <b>2</b> Day <b>11</b> Year <b>66</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-18-12</b>	9. AGE (In years last birthday) <b>53</b> yrs.	IF UNDER 1 YEAR Months <b>53</b> Days <b>19</b>	IF UNDER 24 HRS. Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Janitor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Steel Making</b>		11. BIRTHPLACE (State or foreign country) <b>Fayetteville, N. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Foster McNeill</b>				14. MOTHER'S MAIDEN NAME <b>Lillie Burns</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>240-12-2073</b>		17. INFORMANT <b>Martha McNeill - 2310 Mt. Royal Terrace</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> <b>443X</b> DUE TO (b) <b>Congestive Heart Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>Hypertensive Cardiovascular Disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>						INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Theo C. Patterson</b>				22. DATE SIGNED <b>2/12/66</b>			
EXAMINER'S NAME (Type) <b>THEO. C. PATTERSON</b>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>2-17-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Memorial Park</b>	
24. FUNERAL DIRECTOR <b>Charles R. Law</b>				ADDRESS <b>802 Madison Ave., Balto., Md.</b>		25a. REC'D BY REGISTRAR <b>FEB 14 1966</b> 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

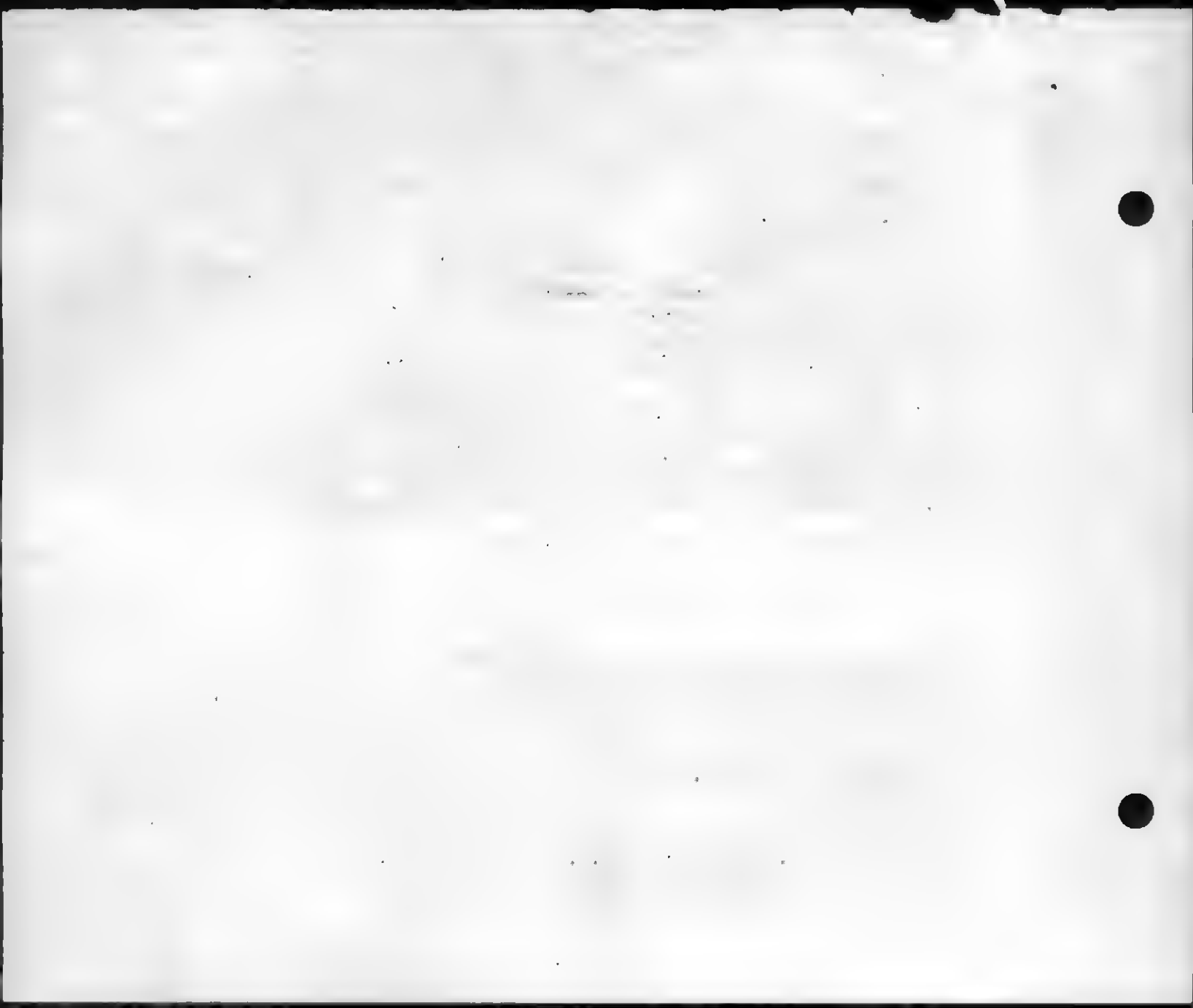
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

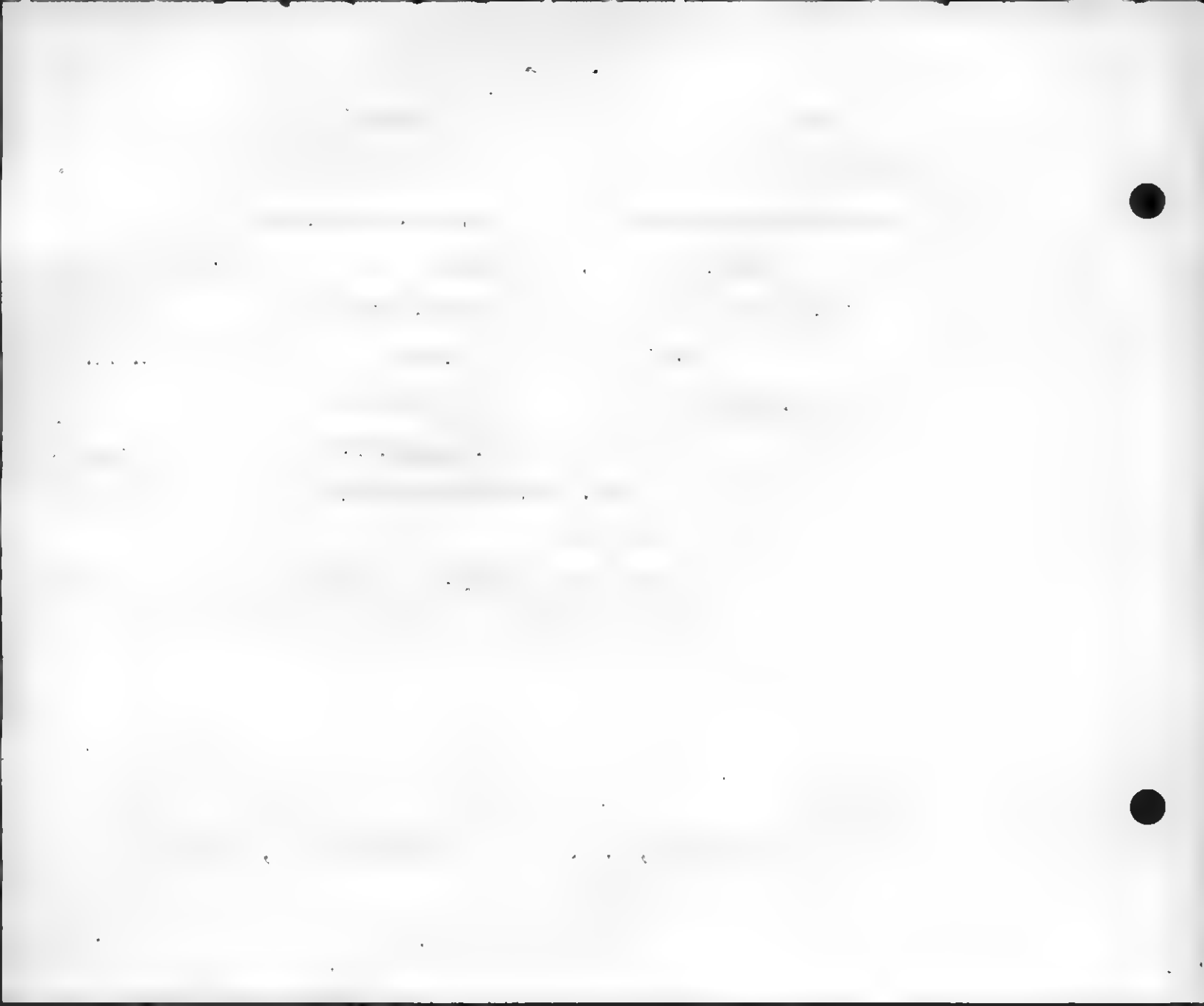
<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>											
<b>1. PLACE OF DEATH</b> <b>a. COUNTY</b> <div style="text-align: center;">Baltimore</div>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) <b>a. STATE</b> <div style="text-align: center;">Maryland</div>					
<b>b. CITY OR TOWN</b> (if outside corporate limits, write RURAL and give nearest town) <div style="text-align: center;">Baltimore</div>						<b>c. LENGTH OF STAY IN 1b</b> <div style="text-align: center;">Life</div>					
<b>d. NAME OF HOSPITAL OR INSTITUTION</b> (if not in hospital, give street address) <div style="text-align: center;">St. Joseph Hospital</div>						<b>d. STREET ADDRESS</b> <div style="text-align: center;">8501 Harford Rd 21234</div>					
<b>3. NAME OF DECEASED</b> <b>(Type or print)</b> <div style="text-align: center;">First Middle Last Robert Andrew MEYERS</div>						<b>4. DATE OF DEATH</b> <div style="text-align: center;">Month Day Year February 24 1966</div>					
<b>5. SEX</b> <div style="text-align: center;">male</div>		<b>6. COLOR OR RACE</b> <div style="text-align: center;">white</div>		<b>7. MARRIAGE</b> <div style="text-align: center;">NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></div>		<b>8. DATE OF BIRTH</b> <div style="text-align: center;">3/27/01</div>		<b>9. AGE</b> (In years last birthday) <div style="text-align: center;">64 yrs.</div>		<b>IF UNDER 1 YEAR</b> <div style="text-align: center;">Months Days Hours Min.</div>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <div style="text-align: center;">BUFFER</div>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <div style="text-align: center;">Bendix Co</div>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <div style="text-align: center;">Maryland</div>				<b>12. CITIZEN OF WHAT COUNTRY?</b> 	
<b>13. FATHER'S NAME</b> <div style="text-align: center;">William Meyers</div>						<b>14. MOTHER'S MAIDEN NAME</b> <div style="text-align: center;">Mary</div>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <div style="text-align: center;">NO</div>				<b>16. SOCIAL SECURITY NO.</b> <div style="text-align: center;">220-07-1784</div>		<b>17. INFORMANT</b> <div style="text-align: center;">Louis Meyers</div>				<b>Address</b> <div style="text-align: center;">2522 Wendover Rd</div>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <b>PART I. DEATH WAS CAUSED BY:</b>  <b>IMMEDIATE CAUSE (a)</b>  <div style="text-align: center;">Carcinoma of adrenals with widespread metastases</div> <div style="text-align: center;">DUE TO</div> <div style="text-align: center;">(b) Pneumonia, bilateral</div> <div style="text-align: center;">DUE TO</div> <div style="text-align: center;">(c)</div> </div> <div style="width: 15%;"> <b>INTERVAL BETWEEN ONSET AND DEATH</b>  </div> </div>											
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> 											
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. 19				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that (I) (this hospital) attended the deceased from Jan. 11, 1966, to Feb. 24, 1966, that (I) (we) last saw the deceased alive on Feb. 24, 1966, and that death occurred at 2a M, from the causes and on the date stated above.</b>											
<b>22a. SIGNATURE</b> <div style="text-align: center;">D. R. Govinda Rao</div>						<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/>		<b>22b. DATE SIGNED</b> <div style="text-align: center;">Feb. 24, 1966</div>			
<b>22c. PHYSICIAN'S NAME (Type)</b> <div style="text-align: center;">D. R. Govinda Rao, M.D.</div>						<b>22d. ADDRESS</b> <div style="text-align: center;">7620 York Road, Towson 4, Md.</div>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <div style="text-align: center;">BURIAL</div>		<b>23b. DATE THEREOF</b> <div style="text-align: center;">2-28-66</div>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <div style="text-align: center;">Moreland Memorial</div>		<b>23d. LOCATION</b> (City, town or county) (State) <div style="text-align: center;">Baltimore Md</div>					
<b>24. FUNERAL DIRECTOR</b> <div style="text-align: center;">C. F. EVANS + Son</div>				<b>ADDRESS</b> <div style="text-align: center;">8802 Harford Rd</div>		<b>25a. REC'D BY REGISTRAR</b> <div style="text-align: center;">FEB 28 1966</div>		<b>25b. REGISTRAR'S SIGNATURE</b> <div style="text-align: center;">John Charles Judge</div>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b> c. LENGTH OF STAY IN 1b <b>14 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>				<b>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</b> a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> d. STREET ADDRESS <b>2718 ORLEANS STREET</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) <b>FREDERICK W. MONATH</b>				<b>4. DATE OF DEATH</b> Month <b>FEBRUARY</b> Day <b>10</b> Year <b>1966</b>				<b>5. SEX</b> <b>MALE</b> <b>6. COLOR OR RACE</b> <b>WHITE</b> <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <b>JULY 10, 1904</b> <b>9. AGE (In years last birthday)</b> <b>61 yrs.</b> <b>10. IF UNDER 1 YEAR</b> Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>			
<b>11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b> <b>PLUMBER</b> <b>11b. KIND OF BUSINESS OR INDUSTRY</b> <b>PLUMBING</b> <b>11. BIRTHPLACE (County &amp; State, or foreign country)</b> <b>BALTIMORE, MARYLAND</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>				<b>13. FATHER'S NAME</b> <b>FREDERICK H. MONATH</b> <b>14. MOTHER'S MAIDEN NAME</b> <b>ELSIE GRENGER</b>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)</b> <b>YES</b> <b>16. SOCIAL SECURITY NO.</b> <b>215 09 2182</b> <b>17. INFORMANT</b> <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>			
<b>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</b> <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <b>PNEUMONIA, UNDETERMINED ORGANISM</b> <b>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.</b> <b>(b) ATELECTASIS</b> <b>(c) SQUAMOUS CELL CARCINOMA, RIGHT LUNG</b> <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b> <b>19. WAS AUTOPSY PERFORMED?</b> <b>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>											
<b>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <b>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</b> <b>20c. TIME OF INJURY</b> Month, Day, Year <b>19</b> Hour a.m. <b>0</b> p.m. <b>0</b> <b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/> <b>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</b> <b>20f. (City or town) (County) (State)</b> <b>21. I certify that (this hospital) attended the deceased from 1/27/66, 19 to 2/10/66, 19, that (we) last saw the deceased alive on 2/10/66, 19, and that death occurred at 2:35 PM from the causes and on the date stated above.</b> <b>22a. SIGNATURE</b> <i>Neilon Neilson</i> <b>M.D.</b> <b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/> <b>22b. DATE SIGNED</b> <b>2/11/66</b> <b>22c. PHYSICIAN'S NAME (Type)</b> <b>NEILON NEILSON, M. D.</b> <b>22d. ADDRESS</b> <b>VAH FORT HOWARD, MARYLAND</b>											
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>BURIAL</b> <b>23b. DATE THEREOF</b> <b>2/14/66</b> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>PARKWOOD CEMETERY</b> <b>23d. LOCATION (City, town or county) (State)</b> <b>BALTIMORE, MARYLAND</b>				<b>24. FUNERAL DIRECTOR</b> <b>ADDRESS</b> <b>ULLRICH FUNERAL HOME</b> <b>BELAIR ROAD, BALTIMORE, MD.</b> <b>25a. REC'D BY REGISTRAR</b> <b>25b. REGISTRAR'S SIGNATURE</b> <b>FEB 16 1966</b> <i>Charles Judge</i>							



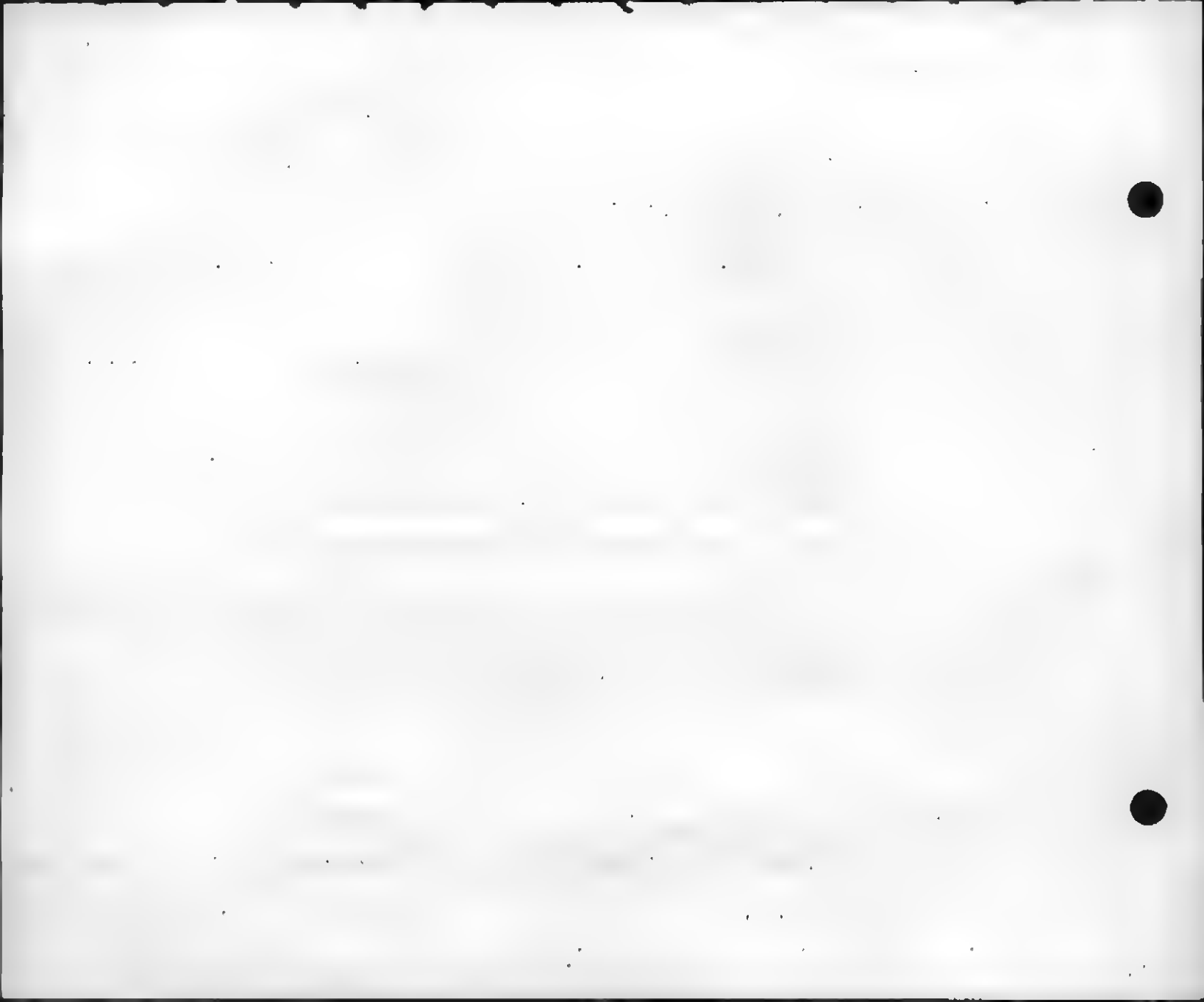
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

M

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>✓</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>MARYLAND</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>House in the Pines, Catonsville, Maryland</b>		e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
3. NAME OF DECEASED (Type or print) <b>Margaret M. Morrow</b>		4. DATE OF DEATH <b>February 4, 1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 24, 1894</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		9b. AGE (In years last birthday) <b>71</b> yrs. IF UNDER 1 YEAR: Months Days Hours Min.	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>	
13. FATHER'S NAME <b>Francis Cook</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Virginia Crooks, 1301 Birch Ave, 21227</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Decompensation</b> <b>+ 1001</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>12 mos.</b> <b>10 70</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>3-27-</b> , 1965, to <b>2-4</b> , 1966, that (I) (we) last saw the deceased alive on <b>2-1-</b> 1966, and that death occurred at <b>1:44 PM</b> , from the causes and on the date stated above.	
22a. SIGNATURE <b>Wilmer K. Gallagher, Sr.</b>		22b. DATE SIGNED <b>2-4-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Wilmer K. Gallagher, Sr.</b>		22d. ADDRESS <b>6209 Frederick Ave. Balt. 21228 Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Feb. 7, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR <b>G. Truman Schwab, 3512 Frederick Ave, Baltimore Md. 21229</b>		25a. REC'D BY REGISTRAR <b>FEB 7 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



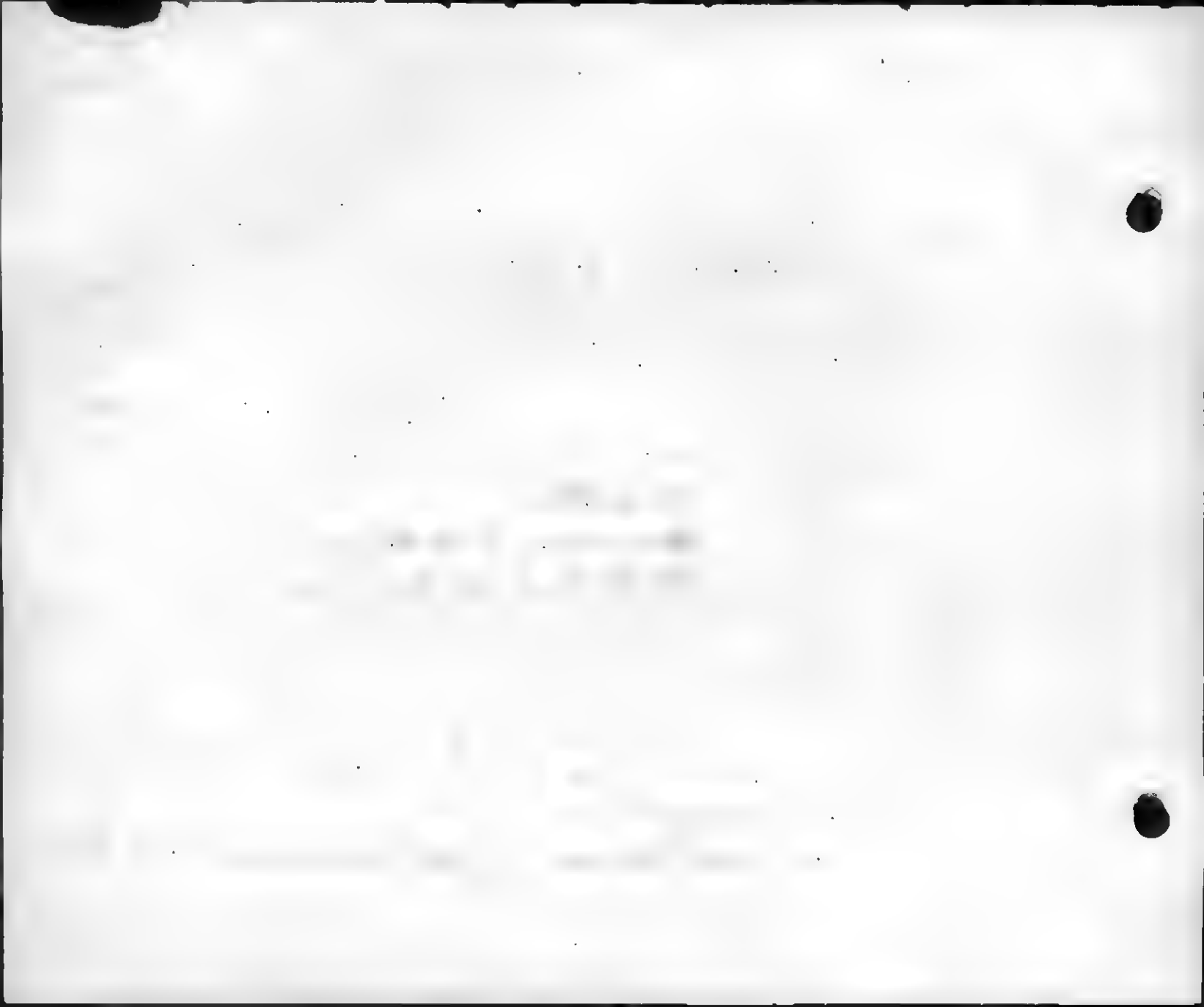
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
02002  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c. LENGTH OF STAY IN 1b <u>3 mos.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Balto. Medical Center</u>				e. STREET ADDRESS <u>Box 111 Morse, Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>ARMOREL</u> Middle <u>MORSE</u> Last				4. DATE OF DEATH Month <u>Feb.</u> Day <u>17</u> Year <u>1966</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Can.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. AGE (In years last birthday) <u>48</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>OFFICE SUPERVISOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>INSURANCE</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Connecticut</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>James M. Morse</u>				14. MOTHER'S MAIDEN NAME <u>Armored MURRAY</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>218-03-7023</u>		17. INFORMANT (Mother) <u>Armored Morse</u>		Address <u>Box 111 Morse Rd. Forest Hill, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma</u> DUE TO (b) <u>Carcinoma of Recto-Sigmoid.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Metastasis to liver and lungs.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u> <u>2 years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11-5</u> , 19 <u>65</u> , to <u>2-17</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2-16</u> , 19 <u>66</u> , and that death occurred at <u>7:25</u> PM, from the causes and on the date stated above.							
22a. SIGNATURE <u>Luis Raul Takagi</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>3/18/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>LUIS RAUL TAKAGI</u>				22d. ADDRESS <u>605 BALTIMORE AVE. Towson</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/20/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>William Matten</u>		23d. LOCATION (City, town or county) (State) <u>Coatons Maryland</u>	
24. FUNERAL DIRECTOR <u>Charles E. Kurtz</u>				ADDRESS <u>Jarrettsville, Md.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
				25b. REGISTRAR'S SIGNATURE			

DATE FEB 21 1966



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

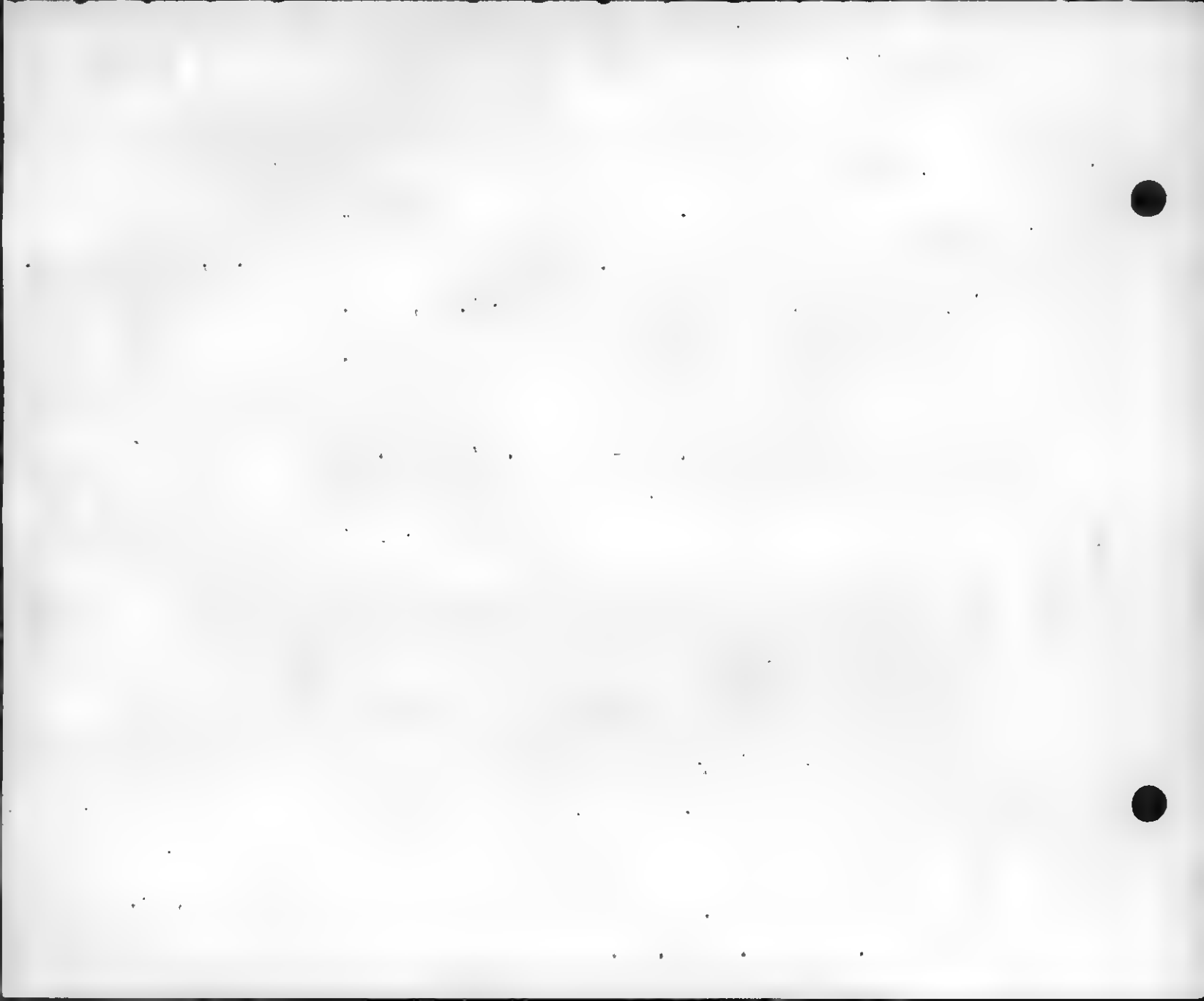
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02003

01951

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural-- Baltimore</b>		c. LENGTH OF STAY IN ID <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		d. STREET ADDRESS <b>6702 Sherwood Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Irene</b>		First <b>Irene</b>		Middle <b>S.</b>		Last <b>Moxley</b>		4. DATE OF DEATH <b>Feb. 7, 19 66.</b>		Month <b>Feb.</b>		Day <b>7</b> Year <b>19 66.</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 16, 1900.</b>		9. AGE (In years last birthday) <b>65</b> yrs.		IF UNDER 1 YEAR Months <b>65</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>McAvoy</b>		14. MOTHER'S MAIDEN NAME <b>Catherine McIntyre</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-18-8508</b>		17. INFORMANT <b>Mr. William C. Moxley</b>		Address <b>(Same)</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intracranial Tumor - Psammoma</b> <b>1x3x</b> DUE TO (b) <b>ganglioneurofibroma</b> DUE TO (c) <b>ganglioneurofibroma</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>at least 7 months!</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>2/19</b> , 19 <b>65</b> , to <b>2/7</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>2/7</b> , 19 <b>66</b> , and that death occurred at <b>10 PM</b> , from the causes and on the date stated above.	
22a. SIGNATURE <b>Robert W. Gebhardt MD</b>		22b. DATE SIGNED <b>2/8/66</b>		22c. PHYSICIAN'S NAME (Type) <b>ROBERT W. GEBHARDT MD</b>		22d. ADDRESS <b>1211 NORTHERN PKWY. BALTO, MD</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/11/66.</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/11/66.</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>		24. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc. Balto. Md. 21214</b>		25a. REC'D BY REGISTRAR <b>FEB 10 1966</b>		25b. REGISTRAR'S SIGNATURE <b>W. J. Ruck</b>	

MEDICAL CERTIFICATION



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please attach carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

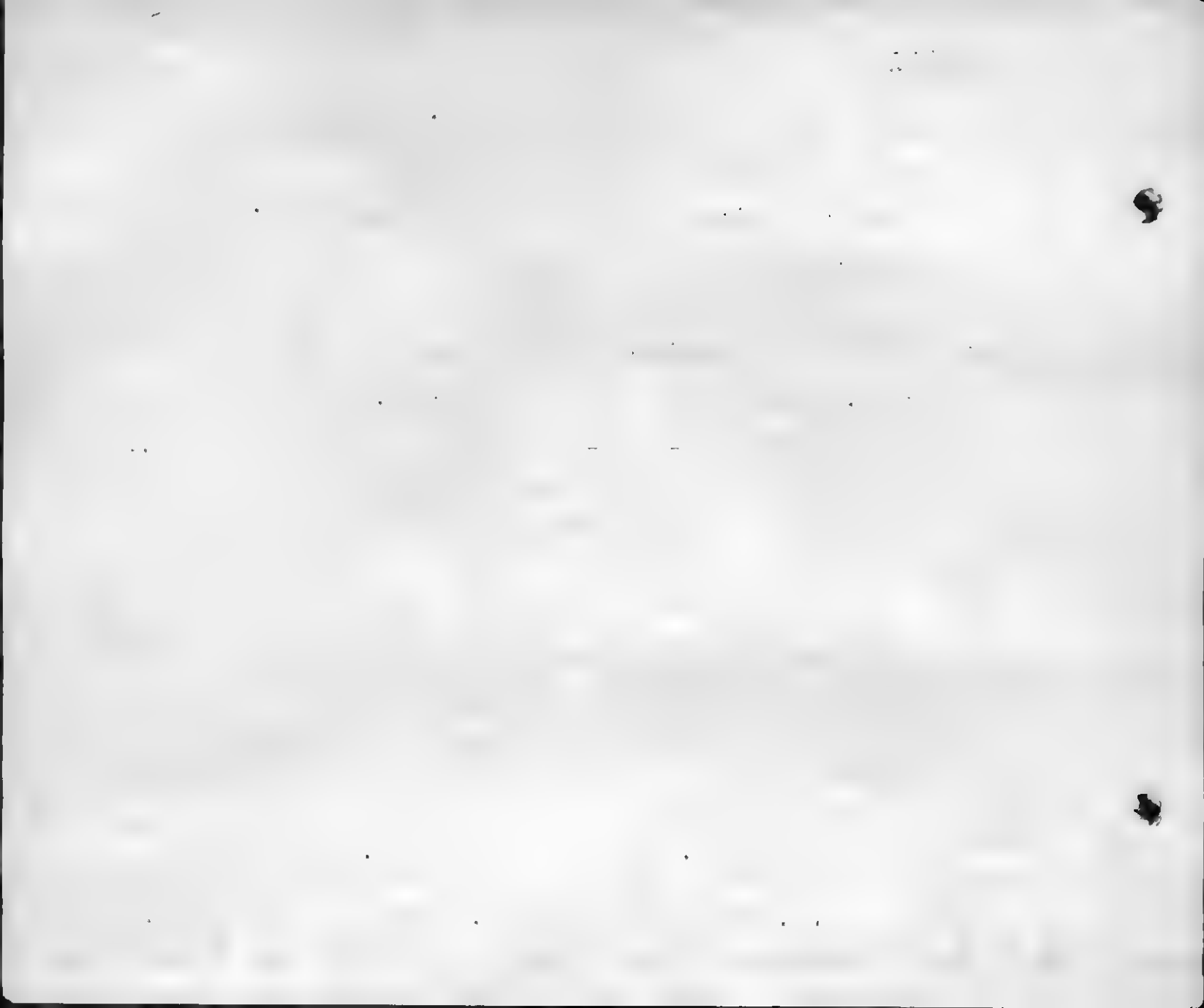
## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

### CERTIFICATE OF DEATH

02004

01952

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u> c. LENGTH OF STAY IN 1b <u>12 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Stella Maris Hospice</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>✓</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>700 Springfield Ave.,</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Katherine Murphy</u> First Middle Last		<b>4. DATE OF DEATH</b> <u>2 / 9 / 66</u> Month Day Year	
<b>5. SEX</b> <u>F</u> <b>6. COLOR OR RACE</b> <u>W</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>11/27/1876</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>89</u> yrs.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Clerical work</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Secretarial Work</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Baltimore</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>John V. Murphy</u> <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> <b>16. SOCIAL SECURITY NO.</b> <u>220-222506-A</u> <b>17. INFORMANT</b> <u>Sarah O. Sollers</u> Address <u>13 Florida Ave., Towson</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>1. Cerebral Vascular Accident</u> DUE TO (b) <u>2. Accid.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u> Hour e.m. p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	
<b>20f. (City or town)</b>		<b>20g. (County)</b>	
<b>20h. (State)</b>		<b>20i. (State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from.....10/31/53 .., 19 .., to 2/9/66 .., 19....., that (I) (we) last saw the deceased alive on...2/8/66 .., and that death occurred at.....A.....M, from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>Robert J. Mahon</u> <b>22c. PHYSICIAN'S NAME (Type)</b> <u>Robert J. Mahon</u>		<b>22b. DATE SIGNED</b> <u>2/9/66</u> <b>22d. ADDRESS</b> <u>204 E. Joppa Rd Towson</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u> <b>23b. DATE THEREOF</b> <u>Feb. 14, 1966</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Dulaney Valley Mem. Gardens</u> <b>23d. LOCATION (City, town or county)</b> <u>Cockeysville, Maryland</u>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John Burns, Towson, Md.</u> <b>25a. REC'D BY REGISTRAR</b> <u>FEB 14 1966</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>									
<b>1. PLACE OF DEATH</b> a. COUNTY <b>BAITMORE</b> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b> c. LENGTH OF STAY IN 1b <b>81 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>					<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> d. STREET ADDRESS <b>1 S. EAST AVENUE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
<b>3. NAME OF DECEASED</b> (Type or print) First <b>ALFRED</b> Middle <b>G.</b> Last <b>NAGENGAST</b>			<b>4. DATE OF DEATH</b> Month <b>FEBRUARY</b> Day <b>8</b> Year <b>1966</b>						
<b>5. SEX</b> <b>MALE</b>		<b>6. COLOR OR RACE</b> <b>WHITE</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>2/23/97</b>		<b>9. AGE</b> (In years last birthday) <b>68</b> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Mins. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>CLERK</b>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>HARDWARE STORE</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>BALTIMORE, MARYLAND</b>			<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>GEORGE NAGENGAST</b>					<b>14. MOTHER'S MAIDEN NAME</b> <b>CATHERINE FRANCE</b>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>YES</b> (If yes give war or dates of service) <b>WW I</b>			<b>16. SOCIAL SECURITY NO.</b> <b>213-05-5801</b>		<b>17. INFORMANT</b> <b>CLIN. RECORDS, VA HOSPITAL FT HOWARD, MARYLAND</b> Address _____				
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <b>GLIOBLASTOMA MULTIFORME RIGHT FRONTAL AREA</b> <b>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.</b> <b>ARTERIOSCLEROTIC HEART DISEASE</b> <b>DUE TO (b)</b> <b>(c)</b>									<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>UNKNOWN</b>
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>									<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)						
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. _____ p.m. <b>19</b>			<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)		
<b>21. I certify that (if this hospital attended the deceased from 11/9/65, 19 to 2/8/66, 19, that (I) (we) last saw the deceased alive on 2/8/66 19 and that death occurred at 9:50 PM from the causes and on the date stated above.</b>									
<b>22a. SIGNATURE</b> <i>William B. Kingree</i>					<b>22b. DATE SIGNED</b> <b>2/9/66</b>		<b>22c. PHYSICIAN'S NAME (Type)</b> <b>WILLIAM B. KINGREE, M. D.</b>		
					<b>22d. ADDRESS</b> <b>VAH FORT HOWARD, MARYLAND</b>				
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>BURIAL</b>			<b>23b. DATE THEREOF</b> <b>2-12-1966</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Parkwood</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>BALTIMORE, MARYLAND</b>		
<b>24. FUNERAL DIRECTOR</b> <b>Lilly &amp; Zeiler Funeral Home</b> <b>Eastern Ave. Baltimore, Md</b>					<b>25a. REC'D BY REGISTRAR</b> <b>DATE</b> <b>14 1966</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <i>Charles Judge</i>		



THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02006

CERTIFICATE OF DEATH

01954

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mount Wilson</b> c. LENGTH OF STAY IN 1b <b>4 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Mount Wilson State Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>J</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE City</b> d. STREET ADDRESS <b>802 NEWINGTON AVE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
3. NAME OF DECEASED (Type or print) <b>LEMUEL HENRY NAIRNE</b>		4. DATE OF DEATH <b>FEB. 14 1966</b>		5. SEX <b>MALE</b>		6. COLOR OR RACE <b>NEGRO</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6/26/05</b>		9. AGE (In years last birthday) <b>60</b> yrs.		10. FINDER 1 YEAR Months Days		10. FINDER 24 HRS. Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BLOCKER IN CAP &amp; HAT FACTORY</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>MARYLAND</b>				11. BIRTHPLACE (County & State, or foreign country) <b>USA</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>											
13. FATHER'S NAME <b>NORMAN NAIRNE</b>				14. MOTHER'S MAIDEN NAME <b>BESSIE COLLY</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT Address <b>Hosp. records, Mt. Wilson St. Hospital</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>COR PULMONALE</b> DUE TO (b) <b>EMPHYSEMA</b> DUE TO (c) <b>CHRONIC BRONCHITIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																INTERVAL BETWEEN ONSET AND DEATH <b>CHRONIC</b> <b>Uncertain</b> <b>Uncertain</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>MINIMAL TUBERCULOSIS AND RHEUMATIC HEART DISEASE</b>																19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>FEB 10, 1966</b> to <b>FEB 14, 1966</b> , that (I) (we) last saw the deceased alive on <b>FEB 14 1966</b> , and that death occurred at <b>6:30</b> M. from the causes and on the date stated above.																							
22a. SIGNATURE <b>Wm. Newcomer</b>				22b. DATE SIGNED <b>2/14/66</b>				22c. PHYSICIAN'S NAME (Type) <b>Wm. Newcomer, M.D., Superintendent</b>				22d. ADDRESS <b>Mount Wilson, Maryland</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>2/15/66</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Carver Mem Park</b>				23d. LOCATION (City, town or county) (State) <b>Baltimore Md</b>											
24. FUNERAL DIRECTOR <b>Adolphus Halstead</b>				ADDRESS <b>1206 N North Ave</b>				25a. REC'D BY REGISTRAR <b>FEB 15 1966</b>				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

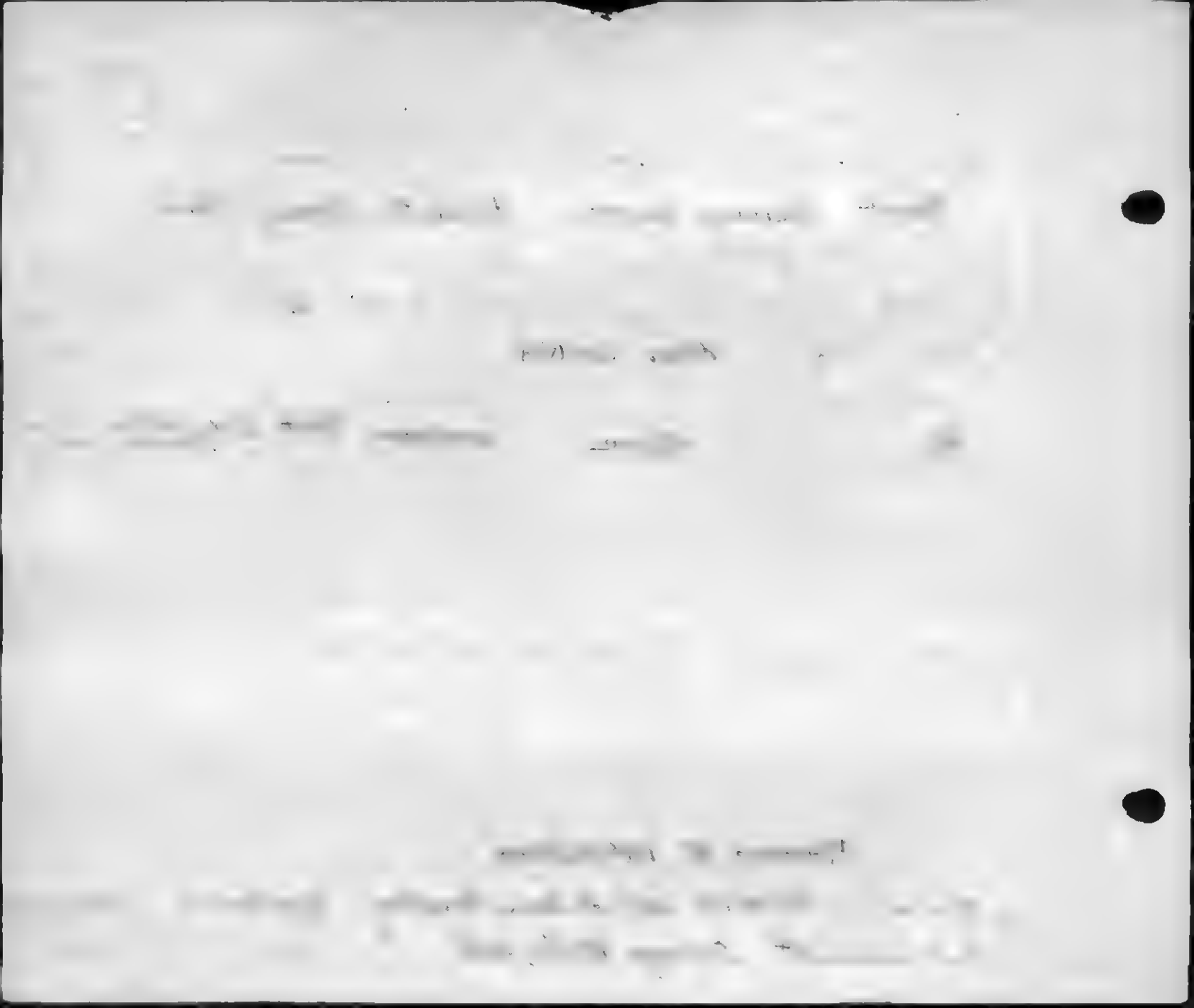
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02007

01955

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u> c. LENGTH OF STAY IN 1b <u>4 months</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Bent Nursing Home</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rehoboth Nursing Home</u> d. STREET ADDRESS <u>Nelson</u>				• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MARGARET</u>		4. DATE OF DEATH Month <u>2</u> Day <u>16</u> Year <u>1966</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>Neg. Ro.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Never Worked</u>		11. BIRTHPLACE (County & State, or foreign country) <u>UNKNOWN</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>UNKNOWN</u>		18. ADDRESS <u>Balto. City Welfare Records</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last, } DUE TO (b) _____ (c) _____										INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 19, 1965</u> to <u>February 16, 1966</u> , that (I) (we) last saw the deceased alive on <u>February 14, 1966</u> , and that death occurred at <u>3:30 PM</u> , from the causes and on the date stated above											
22a. SIGNATURE <u>Clarence E. Williams</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>			
22c. PHYSICIAN'S NAME (Type) <u>Clarence E. Williams</u>				22d. ADDRESS <u>Reisterstown</u>		22b. DATE SIGNED <u>February 16, 1966</u>		22e. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2/18/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cemetery</u>		23d. LOCATION (City, town or county) <u>Baltimore</u>		23e. (State) <u>Maryland</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>H. J. Schhardt</u>				ADDRESS <u>Owings Mills, Md.</u>		25a. REC'D BY REGISTRAR <u>FEB 21 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



## CERTIFICATE OF DEATH

Reg. Dist. No. ....

02008

1966

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>		STATE <u>Maryland</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Quindack</u>		LENGTH OF STAY (in this place) <u>2 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Quindack</u>		LENGTH OF STAY (in this place) <u>2 days</u>	
TOWN <u>Quindack</u>		TOWN <u>Quindack</u>		STREET ADDRESS <u>111 CENTER ST</u>		STREET ADDRESS <u>111 CENTER ST</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>111 CENTER ST</u>				HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>111 CENTER ST</u>			
3. NAME OF DECEASED (Type or Print) <u>Marianne Nelson</u>				4. DATE OF DEATH (Month) <u>Feb.</u> (Day) <u>9</u> (Year) <u>1966</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>C</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>		8. DATE OF BIRTH <u>February 4/10/1910</u>	
9. AGE last birthday <u>55</u> yrs.		10. IF UNDER 1 YEAR Months <u>11</u> Days <u>9</u>		11. IF UNDER 24 HRS. Hours <u>-</u> Min. <u>-</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Stafford, Va.</u>	
13. FATHER'S NAME <u>?</u>				14. MOTHER'S MAIDEN NAME <u>Ide Nelson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Florence Fleming 200 Center St</u>	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				2. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
IMMEDIATE CAUSE (A) <u>Pneumonia (Cystostatic)</u>				DUE TO <u>ANEMIA</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>ANEMIA</u>				DUE TO (C) <u>Nephritis (Chronic)</u>			
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Leaf-vertebral</u>				BIRTH <u>BIRTH</u>			
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				21. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21a. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)				21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> P. <input type="checkbox"/>				21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
21f. HOW DID INJURY OCCUR?				22. I hereby certify that I attended the deceased from <u>July 4</u> , 19 <u>50</u> , to <u>Feb 9</u> , 19 <u>66</u> , that I last saw the deceased alive on <u>Feb 5</u> , 19 <u>66</u> , and that death occurred at <u>7 PM</u> from the causes and on the date stated above.			
SIGNATURE <u>William C. Hilde</u> M.D. <u>140 Oak Ave. Quindack 2321</u>				DATE SIGNED <u>2/9/66</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>				DATE THEREOF <u>2-12-66</u>			
NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn</u>				LOCATION (City, town, or county) <u>Baltimore</u> (State) <u>Md.</u>			
24. REC'D BY REGISTRAR <u>Charles Judge</u>				25. FUNERAL DIRECTOR'S SIGNATURE <u>Morton + Pyett Fun. H. LAURENS</u>			
DATE <u>FEB 10 1966</u>				ADDRESS <u>1701</u>			

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 7 days after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

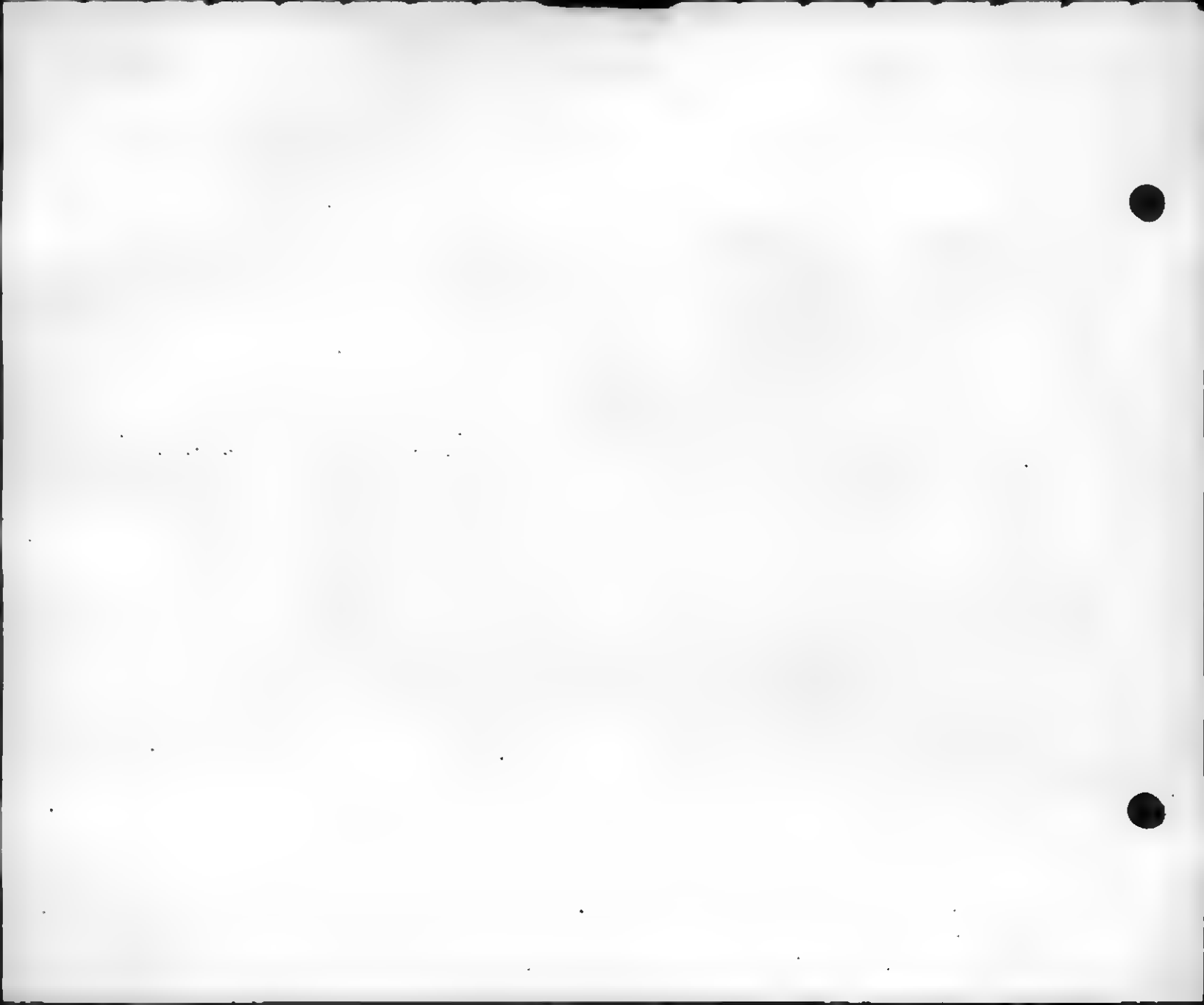
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02009

01957

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>312 ORLEY ROAD</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>M.D.</b> b. COUNTY <b>BALTO</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b> d. STREET ADDRESS <b>170 CHERRY DELL RD.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>KATHERINE</b> Middle <b>SMITH</b> Last <b>NOLAN</b>			4. DATE OF DEATH Month <b>FEB</b> Day <b>11</b> Year <b>1966</b>				
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOV. 4, 1903</b>	9. AGE (In years last birthday) <b>62</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PAINTER</b>		10b. KING OF BUSINESS OR INDUSTRY <b>BENDIX CO.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>VIRGINIA</b>			
13. FATHER'S NAME <b>OSCAR H. LACKEY</b>			14. MOTHER'S MAIDEN NAME <b>LENA L. SMITH</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mr. Frank Cozart - 312 Orley Rd.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> <b>4201</b> DUE TO <b>ASCVD with hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>10d</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					INTERVAL BETWEEN ONSET AND DEATH		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>May 2, 1964</b> to <b>Feb 11, 1966</b> that (I) (we) last saw the deceased alive on <b>Feb 11, 1966</b> and that death occurred at <b>M</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>James E. Rowe</b>			22b. DATE SIGNED <b>2/14/66</b>				
22c. PHYSICIAN'S NAME (Type) <b>JAMES E. ROWE</b>			22d. ADDRESS <b>Catonville 28 Md</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-15-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Catholic Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore Md</b>		
24. FUNERAL DIRECTOR <b>Foley - Conway &amp; General Home Catonville</b>			25a. REC'D BY REGISTRAR <b>FEB 16 1966</b>				
			25b. REGISTRAR'S SIGNATURE <b>J. H. Judge</b>				



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7 62

# MARYLAND STATE DEPARTMENT OF HEALTH

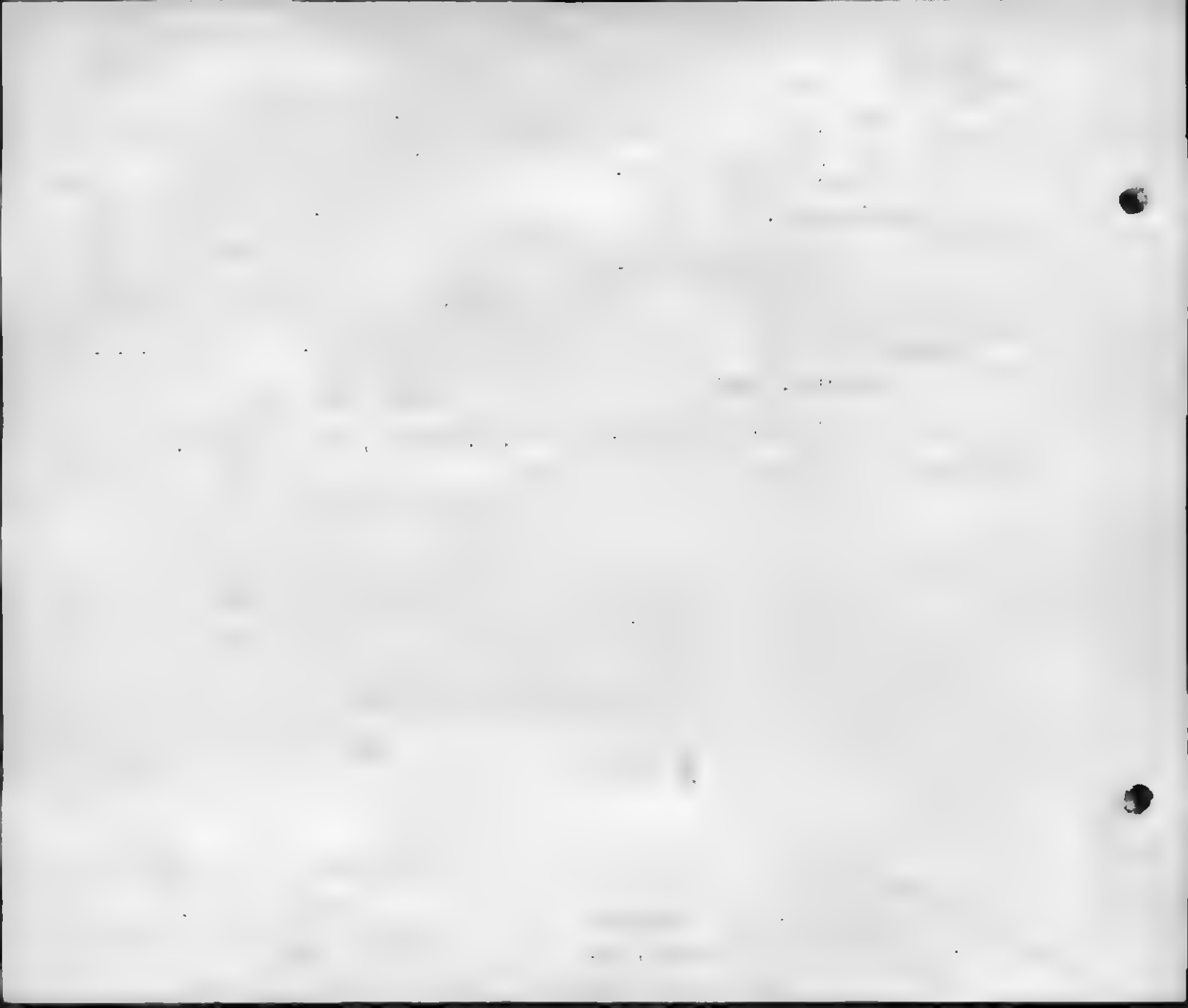
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02010

01258

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Timonium</u> c. LENGTH OF STAY IN 1b <u>3 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>216 Cinder Rd.</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Timonium</u> d. STREET ADDRESS <u>216 Cinder Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Julia Evelyn Norvell</u>		<b>4. DATE OF DEATH</b> Month Day Year <u>2, 19, 1966</u>	
<b>5. SEX</b> <u>F</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>6, 11, 1916</u>
<b>9. AGE</b> (In years last birthday) <u>50</u> yrs.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Baltimore Md.</u>
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>13. FATHER'S NAME</b> <u>Julius E. Smith</u>	
<b>14. MOTHER'S MAIDEN NAME</b> <u>?? NOT KNOWN</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>	
<b>16. SOCIAL SECURITY NO.</b> <u>136 16 2873</u>		<b>17. INFORMANT</b> <u>Wm. D. Norvell, 216, Cinder Rd. Timonium</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the lung with metastases</u> DUE TO (b) <u>None</u> DUE TO (c) <u>None</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
<b>PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <u>None</u>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			
<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m. <u>19</u>			
<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>1966</u> <b>19</b> <u>present</u> , that (I) (we) last saw the deceased alive on <u>2/19/66</u> , and that death occurred at <u>8 P.M.</u> from the causes and on the date stated above			
<b>22a. SIGNATURE</b> <u>Bernard Burgin</u> <b>22b. DATE SIGNED</b> <u>2/19/66</u>			
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>BERNARD BURGIN</u> <b>22d. ADDRESS</b> <u>6721 Reisterstown Rd. Balto. 15, Md.</u>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u> <b>23b. DATE THEREOF</b> <u>2, 23, 66</u>			
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Woodlawn</u> <b>23d. LOCATION</b> (City, town or county) (State) <u>Baltimore, Md.</u>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Wm. Cook-Brooks Towson Towson, Md.</u>			
<b>25a. RECEIVED BY REGISTRAR</b> <u>FEB 24 1966</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>[Signature]</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

BP

02011

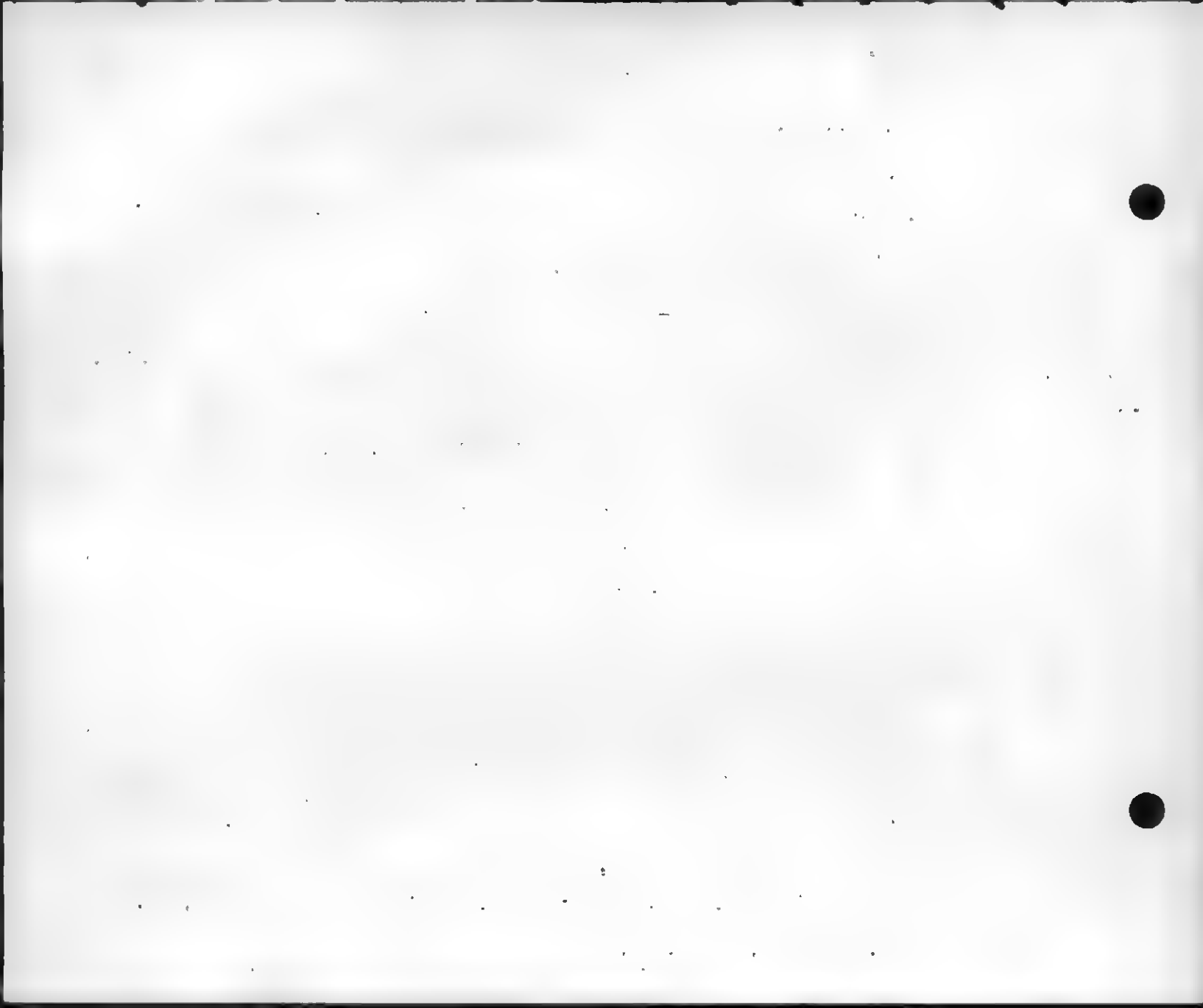
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01959

1. PLACE OF DEATH a. COUNTY <b>Baltimore, Md.</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>St. Joseph Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>6028 Old Harford Rd.</b> <del>Bowson, Maryland</del> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Eleanor</b> Middle <b>L.</b> Last <b>Nye</b>				4. DATE OF DEATH Month <b>Feb.</b> Day <b>13</b> Year <b>19 66</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6/15/77</b>	
9. AGE (In years last birthday) <b>88</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>John Fox</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Miss Thelma Nye</b>		Address <b>(Same)</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute pulmonary edema, congestive heart failure,</b> <b>4341</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>congestive heart failure,</b> DUE TO (c) <b>Arteriosclerotic disease.</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		21. I certify that (I) (this hospital) attended the deceased from <b>2-10-66</b> , 19__, to <b>2-13-66</b> , 19__, that (I) (we) last saw the deceased alive on <b>2-13-66</b> , 19__, and that death occurred at <b>3:10</b> , from the causes and on the date stated above.	
22a. SIGNATURE <b>Reynaldo B. Madrinan</b>		22b. DATE SIGNED <b>2/13/66</b>		22c. PHYSICIAN'S NAME (Type) <b>Dr. Reynaldo B. Madrinan</b>		22d. ADDRESS <b>St. Joseph Hospital</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/16/66.</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem. Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Elkridge, Md.</b>	
24. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc, Balto. Md. 21214</b>		25a. REC'D BY REGISTRAR <b>Feb 14 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. NAME OF CEMETERY OR CREMATORY <b>St. Joseph Hospital</b>	

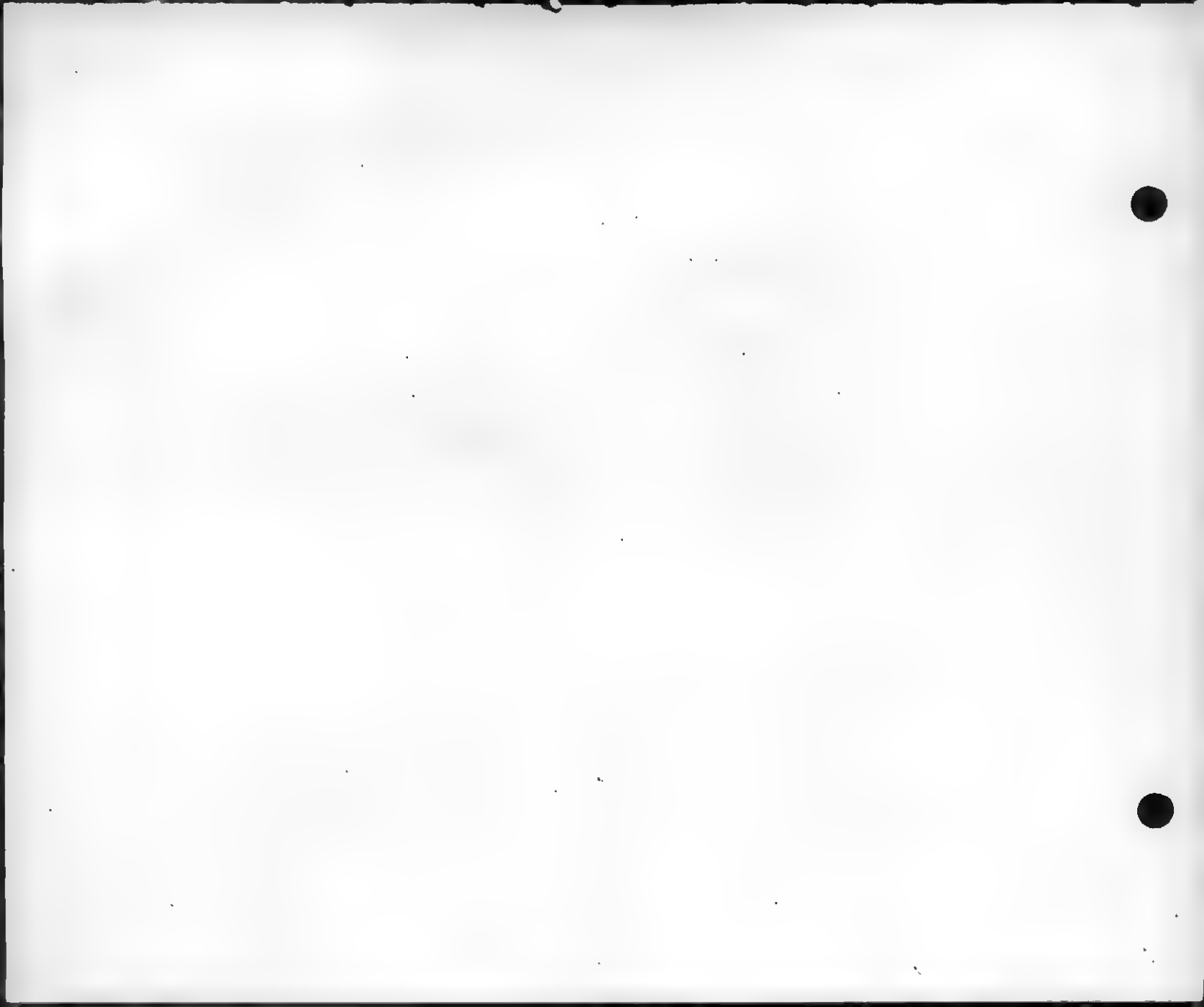


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
02012 CERTIFICATE OF DEATH 01960

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>STEVENSON</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>STEVENSON</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>VILLA JULIE INFIRMARY</u>		d. STREET ADDRESS <u>VALLEY ROAD</u>	
3. NAME OF DECEASED (Type or print) <u>SISTER JULIA OF SACRED HEART (O'MAHONY)</u>		4. DATE OF DEATH Month <u>FEB.</u> Day <u>4</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 2, 1866</u>
9. AGE (In years last birthday) <u>99</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TEACHER-RET.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>IRELAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JEREMIAH O'MAHONEY</u>		14. MOTHER'S MAIDEN NAME <u>MARY TWOMEY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Sister Mary Margaret Villa Julia</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> <u>170X</u> DUE TO (b) <u>Carcinoma of breast</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH <u>6 yrs.</u> <u>10 yrs.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1964</u> , to <u>2-4</u> , 1966, that (I) (we) last saw the deceased alive on <u>2-2</u> 1966, and that death occurred at <u>8:14</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Harold H Burns MD</u>		22b. DATE SIGNED <u>2-4-66</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE THEREOF <u>2-7-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Trinity Convent Cem.</u>	23d. LOCATION (City, town or county) (State) <u>Shicksto, Ind.</u>
24. FUNERAL DIRECTOR <u>July Carrough JA - Catonsville, Ind.</u>		25a. REC'D BY REGISTRAR <u>FEB 7 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Julian J. Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

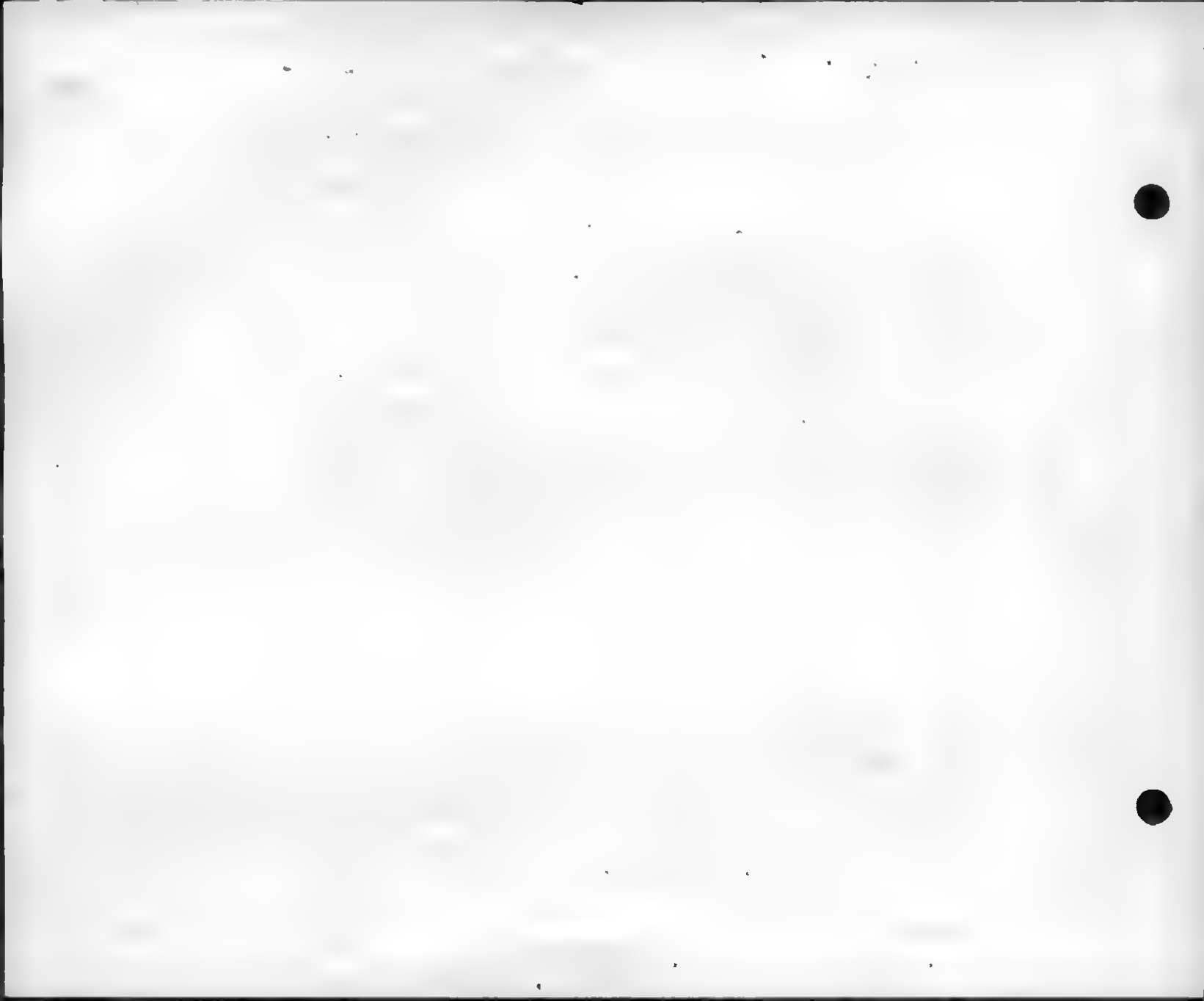
MDARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02013

CERTIFICATE OF DEATH

01961

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c LENGTH OF STAY IN 1b <b>234 DAYS</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		d STREET ADDRESS <b>1 GORSUCH AVENUE</b>	
3 NAME OF DECEASED (Type or print) First <b>TOM</b> Middle <b>A.</b> Last <b>ONIONS</b>		4 DATE OF DEATH Month <b>FEBRUARY</b> Day <b>25</b> Year <b>1966</b>	
5 SEX <b>MALE</b>	6 COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEBRUARY 22, 1899</b>
9 AGE (In years last birthday) <b>67 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SEAMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SHIPPING</b>	11 BIRTHPLACE (County & State, or foreign country) <b>TREDEGAR, S. WALES</b>
12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>ALFRED ONIONS</b>	
14. MOTHER'S MAIDEN NAME <b>SARAH DIX</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW II</b>	
16. SOCIAL SECURITY NO. <b>374 10 6647</b>		17. INFORMANT <b>CLIN RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL THROMBOSIS</b> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CEREBRAL ARTERIOSCLEROSIS</b> DUE TO (c) <b>UNKNOWN</b>			INTERVAL BETWEEN ONSET AND DEATH <b>HOURS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of items 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <b>1/6/65</b> , 19__ to <b>2/25/66</b> , 19__, that (1) (we) last saw the deceased alive on <b>2/25/66</b> , 19__, and that death occurred at <b>1:30 AM</b> from causes and on the date stated above.			
22a. SIGNATURE <i>John D. Talbert</i>		22b. DATE SIGNED <b>2/25/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN D. TALBERT, M. D.</b>		22d. ADDRESS <b>VAH FORT HOWARD, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	23b. DATE THEREOF <b>2/28/1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>LOUDEN PARK</b>	23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MD.</b>
24. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co., 4905 York Road, Baltimore 12, Maryland</b>		25a. REC'D BY REGISTRAR <b>FEB 28 1966</b>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

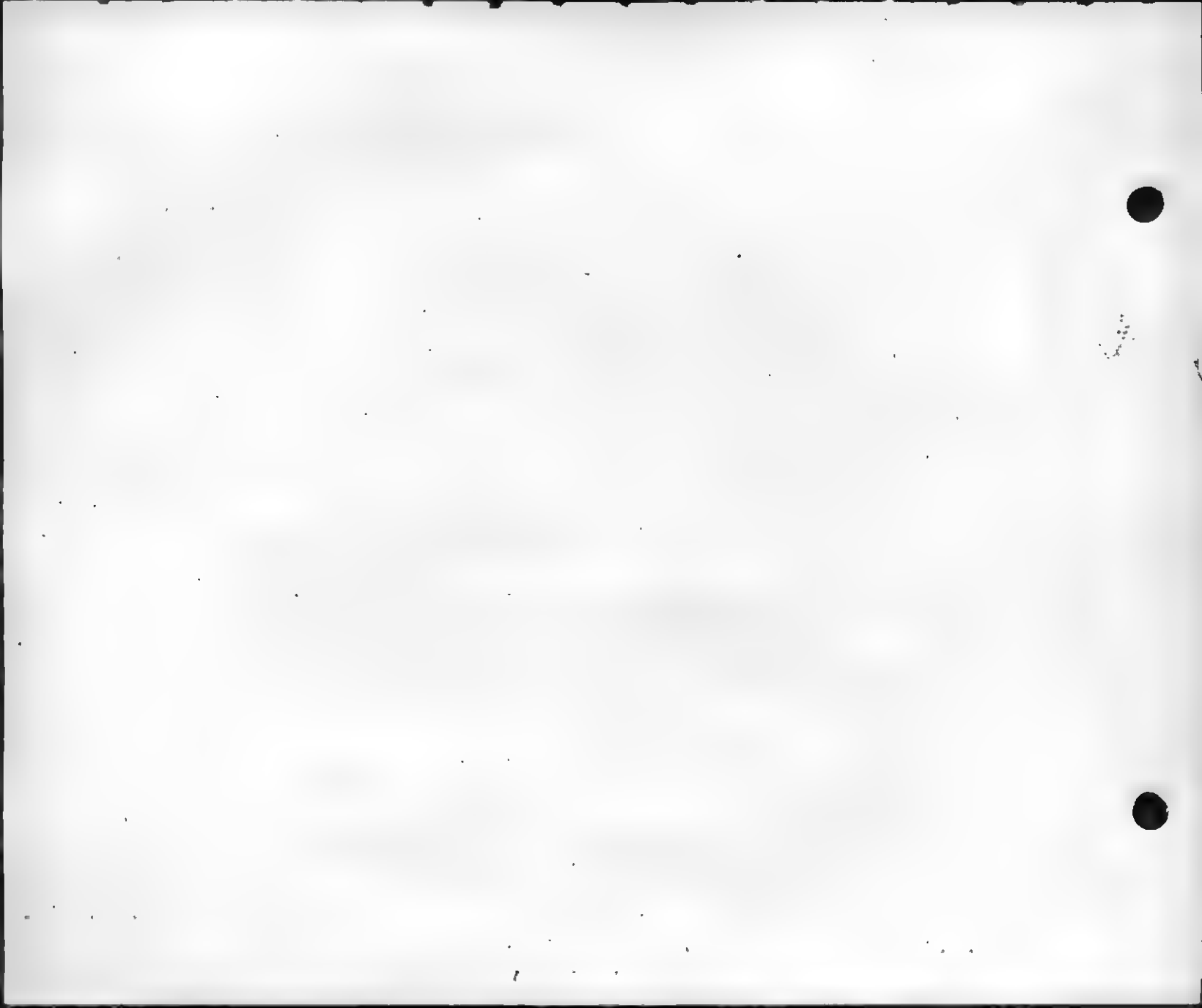


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> <u>TOWSON</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> <u>21218</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>GREATER BALTIMORE MEDICAL CENTER</u>						d. STREET ADDRESS <u>910 CHESTNUT HILL AVE</u>					
3. NAME OF DECEASED (Type or print) <u>ELMER JACOB ORTEL</u>						4. DATE OF DEATH Month <u>2</u> Day <u>11</u> Year <u>1966</u>					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/22/99</u>		9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED - SALES</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>D.S. &amp; D. MOTORS</u>				11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JACOB ORTEL</u>						14. MOTHER'S MAIDEN NAME <u>AMELLIA GABLE</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>216-09-9299</u>		17. INFORMANT <u>CHART</u> Address <u>  </u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEART FAILURE</u>										INTERVAL BETWEEN ONSET AND DEATH <u>4 DAYS</u>	
4 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										(b) <u>ACUTE MYOCARDIAL INFARCTION</u> <u>12 DAYS</u>	
(c) <u>HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> <u>6 YEARS</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Hour a.m. <u>  </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>2/1</u> , 19 <u>66</u> , to <u>2/11</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2/11</u> , 19 <u>66</u> , and that death occurred at <u>10:55 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Oscar Fernandini</u>						M.O. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>2/11/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>OSCAR FERNANDINI</u>						22d. ADDRESS <u>Greater Balto. Medical Center</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>2/14/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>			23d. LOCATION (City, town or county) (State) <u>Woodlawn, Balto. Co., Md.</u>			
24. FUNERAL DIRECTOR <u>H.W. Jenkins &amp; Sons Co.</u> ADDRESS <u>4905 York Road Balto. 12, Md.</u>						25a. REC'D BY REGISTRAR <u>  </u>		25b. REGISTRAR'S SIGNATURE <u>  </u>			
						DATE <u>FEB 14 1966</u>					



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02015

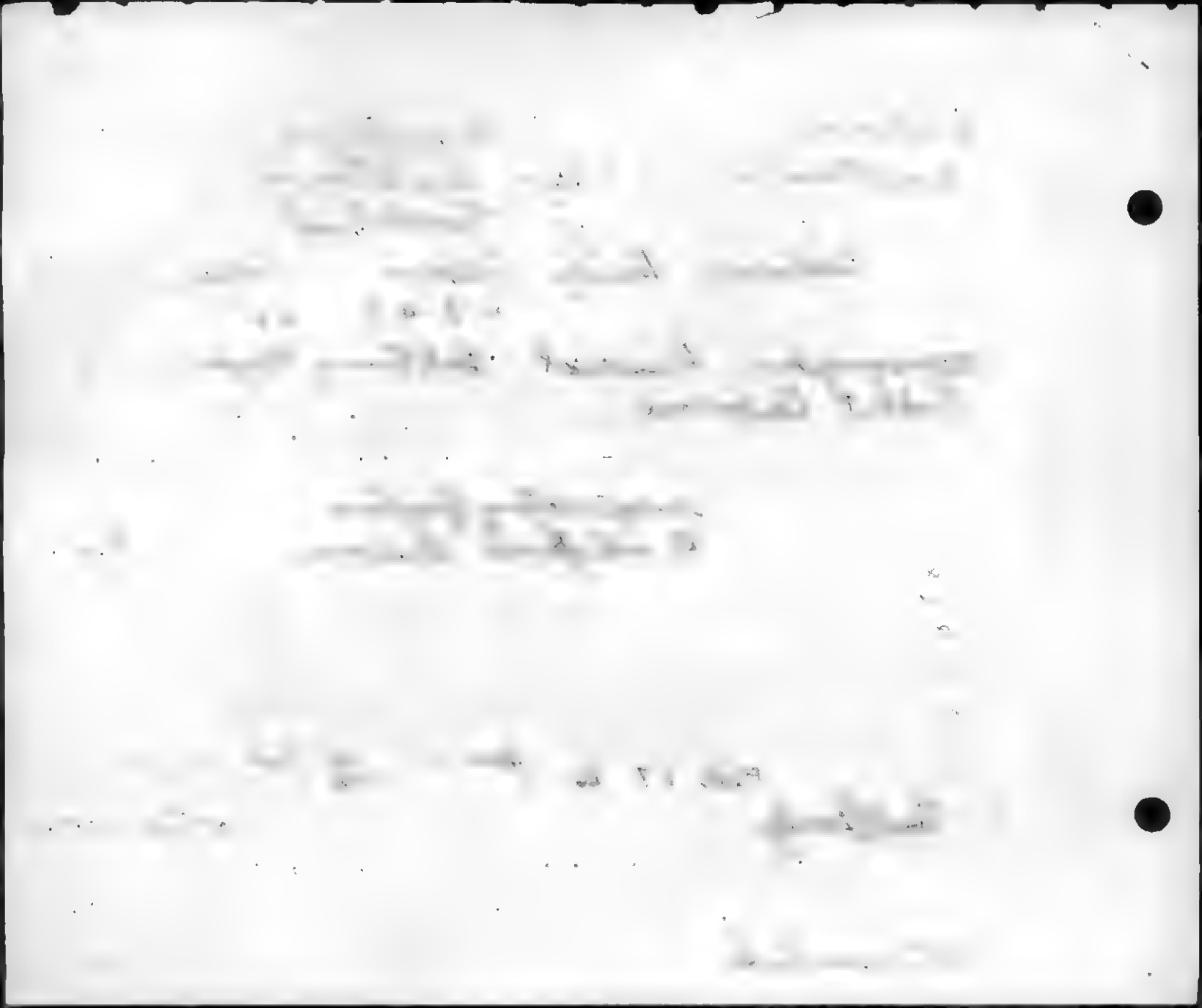
## CERTIFICATE OF DEATH

01963

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Md. Baltimore</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN 1b <u>52 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> Joppa			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>GREATER BALTIMORE MEDICAL CENTER</u>				d. STREET ADDRESS <u>348 B Woodlea Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Belores</u> Middle <u>Raisy</u> Last <u>Osborne</u>				4. DATE OF DEATH Month <u>February</u> Day <u>17</u> Year <u>1966</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-8-43</u>	
9. AGE (In years last birthday) <u>22</u> yrs.		10. AGE 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stenographer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Govt.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland U.S.A.</u>	
13. FATHER'S NAME <u>Robert Osborne</u>				14. MOTHER'S MAIDEN NAME <u>Dora A. Stancill</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-42-0730</u>		17. INFORMANT <u>Robert L. Osborne</u> <u>XXXXXXXXXXXX</u> Joppa, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>respiratory failure</u> <u>201X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hodgkin's disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>DEC 27, 1965</u> to <u>Feb. 17, 1966</u> , that (I) (we) last saw the deceased alive on <u>Feb. 17, 1966</u> , and that death occurred at <u>2:30</u> A.M. from the causes and on the date stated above.							22b. DATE SIGNED <u>Feb. 17/1966</u>
22a. SIGNATURE <u>Edmund Lively</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. PHYSICIAN'S NAME (Type) <u>Edmund Lively, M.D.</u>	
22d. ADDRESS <u>Baltimore, Maryland</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>19 Feb. 66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>		23d. LOCATION (City, town or county) (State) <u>Bel Air, Maryland</u>	
24. FUNERAL DIRECTOR <u>Thelma Macoulas Jr.</u>		25a. REC'D BY REGISTRAR <u>Feb 21 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



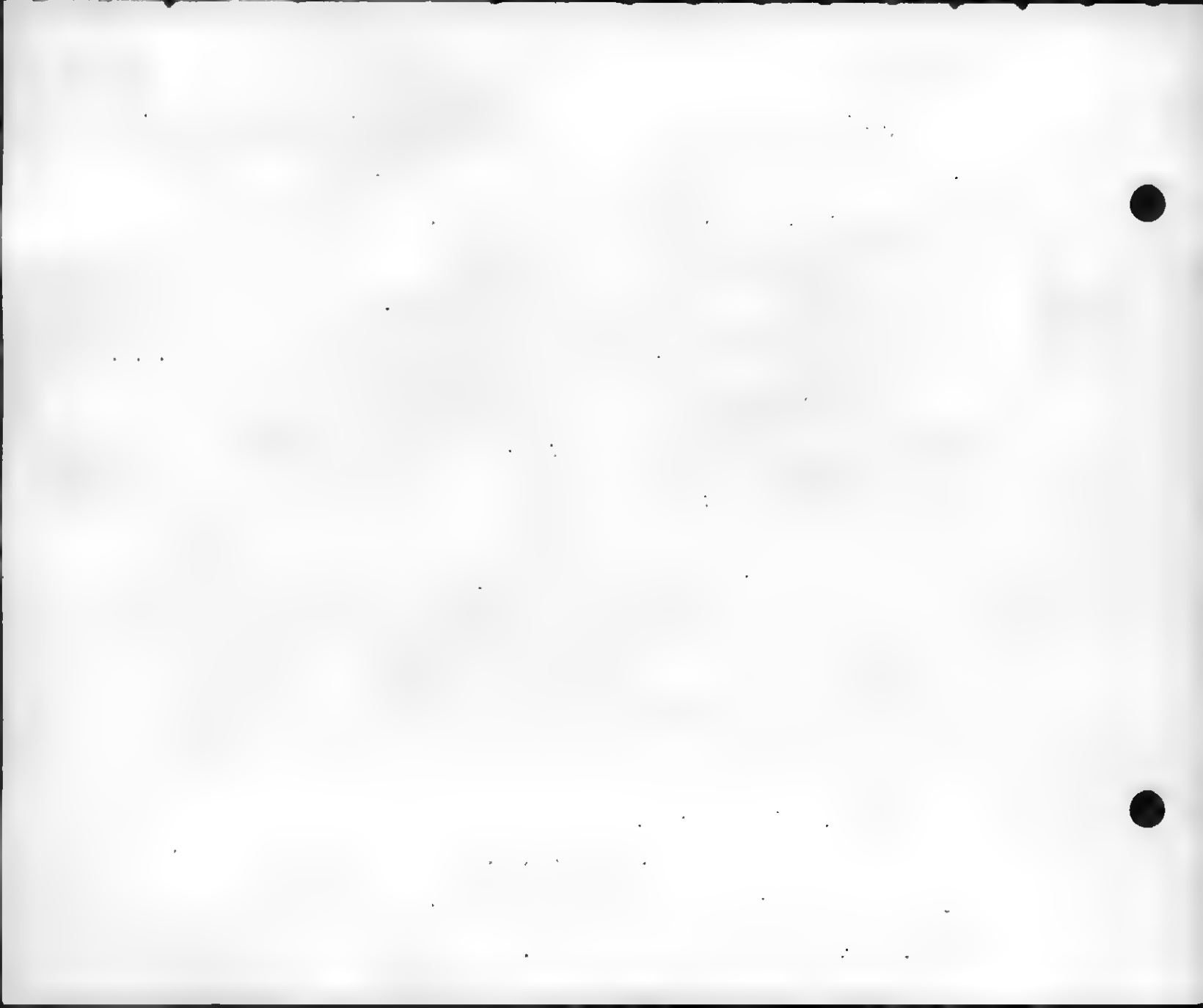
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
02016 CERTIFICATE OF DEATH 01064										
1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>			c. LENGTH OF STAY IN 1b <b>MARYLAND</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>House in the Pines Nursing Home</b>					d. STREET ADDRESS <b>23 E. OSTEN STREET 21230</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>JOHN</b>		First		Middle <b>GEORGE</b>		Last <b>OTTER</b>		4. DATE OF DEATH Month <b>2</b> Day <b>26</b> Year <b>1966</b>		
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7/23/1879</b>		9. AGE (In years last birthday) <b>86</b> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BOX MAKER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>RETIRED</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>AUGUST OTTER</b>					14. MOTHER'S MAIDEN NAME <b>ANNIE FLECKINGER</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NONE</b>			16. SOCIAL SECURITY NO. <b>213-01-1406 A</b>		17. INFORMANT <b>MISS EDNA OTTER, 942 PALLADI DRIVE 21227</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho-pneumonia</b> <b>4221</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Myocarditis</b> DUE TO (c) <b>Generalized arteriosclerosis</b>								INTERVAL BETWEEN ONSET AND DEATH <b>2 wks.</b> <b>1037</b> <b>1577</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>4-28</b> , 1965, to <b>2-28</b> , 1966, that (I) (we) last saw the deceased alive on <b>2-25</b> , 1966, and that death occurred at <b>3:54 AM</b> , from the causes and on the date stated above.										
22a. SIGNATURE <b>Wilmer K. Gallagher, Sr.</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <b>WILMER K. GALLAGHER, SR.</b>					22b. DATE SIGNED <b>2-28-66</b>					
22d. ADDRESS <b>6209 FREDERICK AVENUE - MD 21228</b>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>2/28/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>NEW CATHEDRAL CEMETERY</b>			23d. LOCATION (City, town or county) (State) <b>BALTIMORE MARYLAND</b>			
24. FUNERAL DIRECTOR <b>HUBBARD FUNERAL HOME, 4107 WILKENS AVE. #29</b>					25a. REC'D BY REGISTRAR <b>MAR 2 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. ...</b>			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

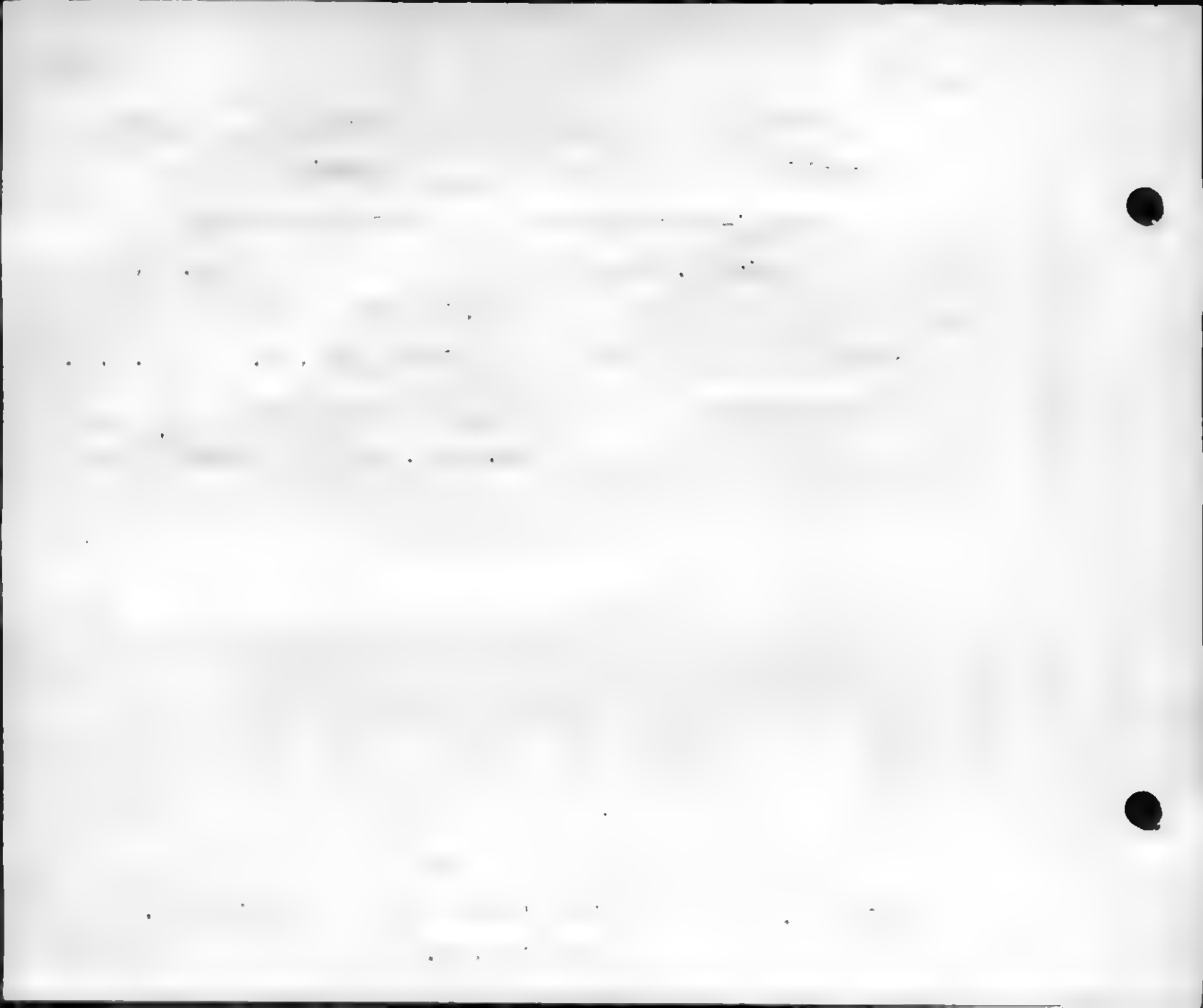
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02017

02050

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN b <b>56 yrs</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Shangri-La Nursing Home</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> d. STREET ADDRESS <b>40 Bloomsbury Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ELiza D. Wrens Wrens</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>22</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 13, 1880</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		9b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	9. AGE (In years last birthday) <b>85 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore City, Md.</b>
13. FATHER'S NAME <b>Warren Paynter</b>		14. MOTHER'S MAIDEN NAME <b>Alice Wilson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Baltimore</b>	
17. INFORMANT <b>Mrs. Eva S. Rote</b>		Address <b>Md. 21207</b> <b>3827 Ferndale Avenue</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO <b>arterio sclerosis</b> DUE TO <b>age</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>4 hrs.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>5/3</b> , 19 <b>57</b> , to <b>2/22</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>2/13</b> , 19 <b>66</b> , and that death occurred at <b>3:30</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>CLIFFE RATLIFF, JR</b>		22b. DATE SIGNED <b>2/23/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>CLIFFE RATLIFF, JR</b>		22d. ADDRESS <b>4605 Edmonson ave #29</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Feb. 24, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Christ Episcopal Church</b>	23d. LOCATION (City, town or county) (State) <b>Owensville, Md.</b>
24. FUNERAL DIRECTOR <b>Easton Funeral Home</b>		25a. REC'D BY REGISTRAR <b>FEB 24 1966</b>	
ADDRESS <b>Catonsville, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



1 (M)  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

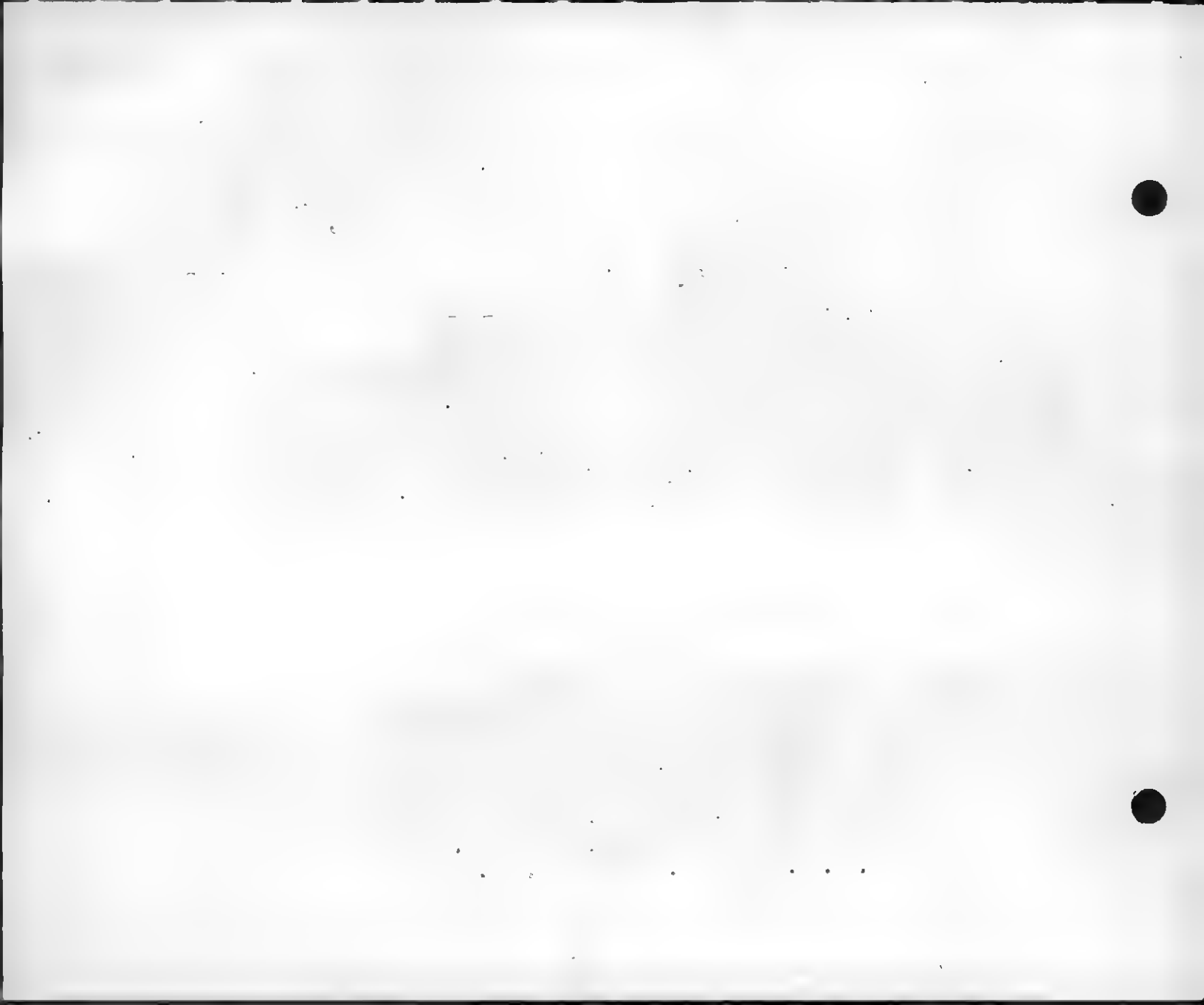
02018

01965

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sparrows Point</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>3905 Cedardale Rd.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Bethlehem Steel Hospital</b>		d. STREET ADDRESS <b>Baltimore</b> <b>Sparrows Point, Maryland</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Richard N, Patterson</b>		4. DATE OF DEATH Month Day Year <b>2-16-66</b> <b>19</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-22-1909</b>
9. AGE (In years last birthday) <b>56 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>56</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Crane operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Steel</b>	
11. BIRTHPLACE (State or foreign country) <b>Summerduck, Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>UNKNOWN</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>213-09-3215</b>	
17. INFORMANT <b>Mrs. Marina Patterson</b>		Address <b>3905 Cedardale Rd.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) <b>Coronary Occlusion</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>None</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>M B Davis MD</b>		22. DATE SIGNED <b>2/16/66</b>	
EXAMINER'S NAME (Type) <b>Dr. M. B. Davis MD. Dundalk 22, MD.</b>		Address (Street, city, town, or county) <b>8800 Mornington Rd.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>2-20-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary Ctry.</b>	23d. LOCATION (City, town or county) (State) <b>Anne Arundel Co., Md.</b>
24. FUNERAL DIRECTOR <b>Randolph Hollick 14126 Preston St.</b>		25. REC'D BY REGISTRAR <b>FEB 21 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

BP 1

02013

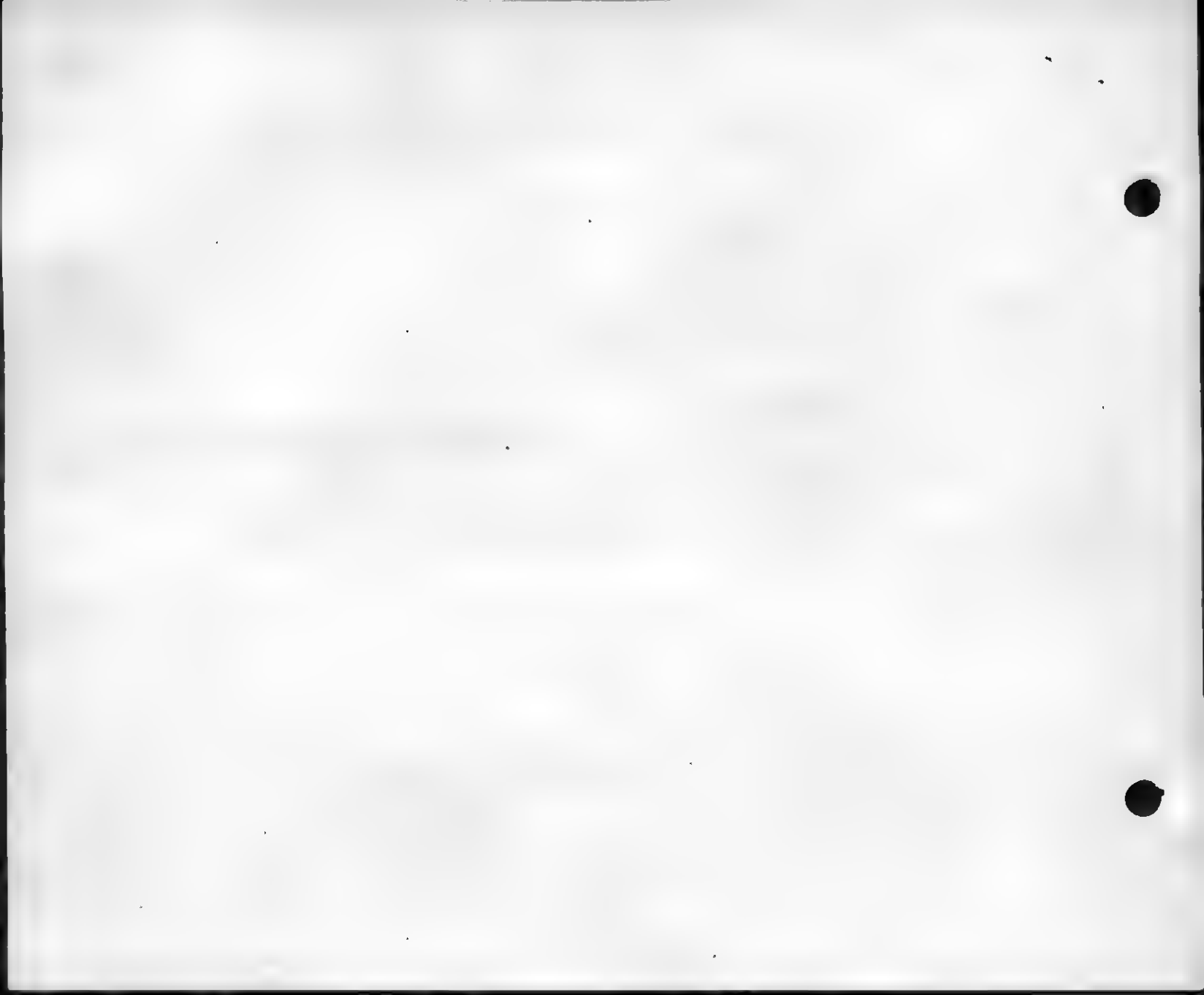
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01066

1. PLACE OF DEATH a. COUNTY <i>Baltimore County</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Randalltown</i>		c. LENGTH OF STAY IN 1b <i>Baltimore</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Baltimore County Gen. Hosp.</i>		e. STREET ADDRESS <i>3502 Sedgemoor Rd</i>	
3. NAME OF DECEASED (Type or print) First <i>Lillie</i> Middle <i>Paul</i> Last <i>Paul</i>		4. DATE OF DEATH Month <i>Feb.</i> Day <i>16</i> Year <i>1966</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 72 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		10b. OF BUSINESS OR INDUSTRY <i>AT HOME</i>	11. BIRTHPLACE (County & State, or foreign country) <i>RUSSIA</i>
13. FATHER'S NAME <i>ELI GARBUS</i>		14. MOTHER'S MAIDEN NAME <i>RIFKA ?</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>MR. MORRIS PAUL</i>		Address <i>3502 SEDGEMOOR ROAD</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypertensive Encephalopathy</i> * X DUE TO (b) <i>Cerebral Thrombosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>Feb. 14</i> , 19 <i>66</i> , to <i>Feb. 16</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>Feb. 16</i> , 19 <i>66</i> , and that death occurred at <i>4 P.</i> M. from the causes and on the date stated above.			
22a. SIGNATURE <i>L. B. Lerma</i>		22b. DATE SIGNED <i>2/16/66</i>	
22c. PHYSICIAN'S NAME (Type) <i>L. B. Lerma</i>		22d. ADDRESS <i>Baltimore County Gen. Hosp.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	23b. DATE THEREOF <i>2/17/66</i>	23c. NAME OF CEMETERY OR CREMATORY <i>MOSES MONTIFLORE WOODMOOR HEBREW</i>	23d. LOCATION (City, town or county) (State) <i>BALTIMORE, MARYLAND</i>
24. FUNERAL DIRECTOR <i>SOL LEVINSON &amp; BROS. INC.</i>		25a. REC'D BY REGISTRAR <i>FEB 21 1966</i>	
ADDRESS <i>6010 REISTERSTOWN RD</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



4.1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

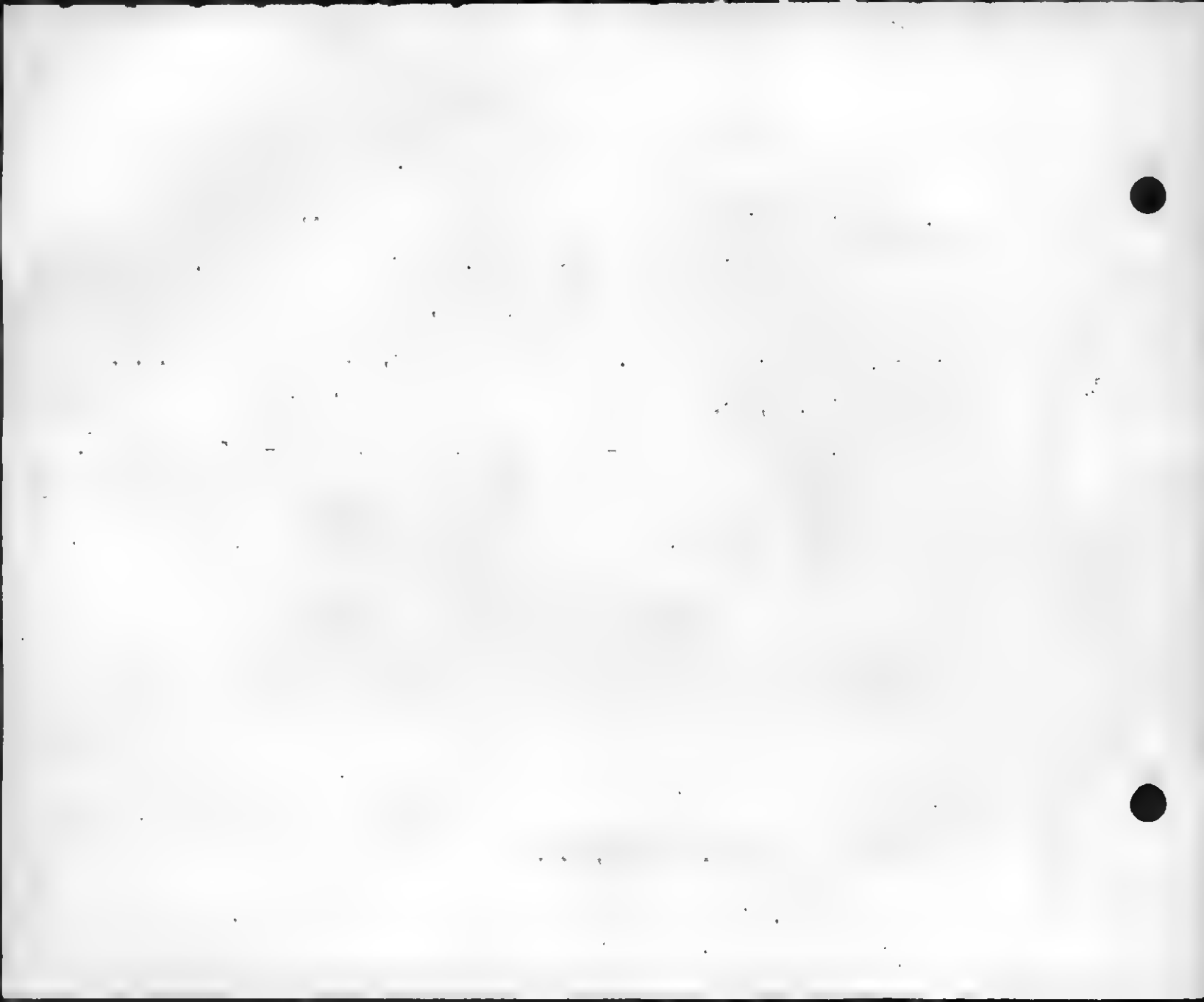
MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH

02020

01967

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>St. Joseph's Hospital</b>				d. STREET ADDRESS <b>301 Morris Ave., Baltimore County</b>			
3. NAME OF DECEASED (Type or print) First <b>Frederick</b> Middle <b>None</b> Last <b>Paxson 3rd</b>				4. DATE OF DEATH Month <b>Feb.</b> Day <b>9</b> Year <b>19 66</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 3, 1906</b>		9. AGE (In years last birthday) <b>59</b> yrs.	IF UNDER 1 YEAR Months <b>7</b> Days <b>6</b> Hours <b></b> Min. <b></b>	IF UNDER 24 HRS Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Probation Officer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Balto. County</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Radnor, Pa</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Frederick Paxson, Jr.</b>				14. MOTHER'S MAIDEN NAME <b>Kathleen Williams</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		(If yes give war or dates of service) <b>Marines</b>		16. SOCIAL SECURITY NO. <b>212-07-7159</b>		17. INFORMANT <b>Margaret Reese Paxson-</b> Address <b>301 Morris Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocardial infarction</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Insufficiency</b> DUE TO (c) <b></b>						INTERVAL BETWEEN ONSET AND DEATH <b>30 min</b> <b>6 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 1, 1957</b> to <b>Feb 9, 1966</b> , that (II) (we) last saw the deceased alive on <b>Feb 9, 1966</b> , and that death occurred at <b>4 P</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Margaret T. Gilmore</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Feb 10, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>George T. Gilmore, M.D.</b>				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>Feb. 10, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount Crematorium</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR <b>John Burns' Sons, Towson, Maryland</b>				25a. REC'D BY REGISTRAR <b>DATE FEB 14 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

B.P.



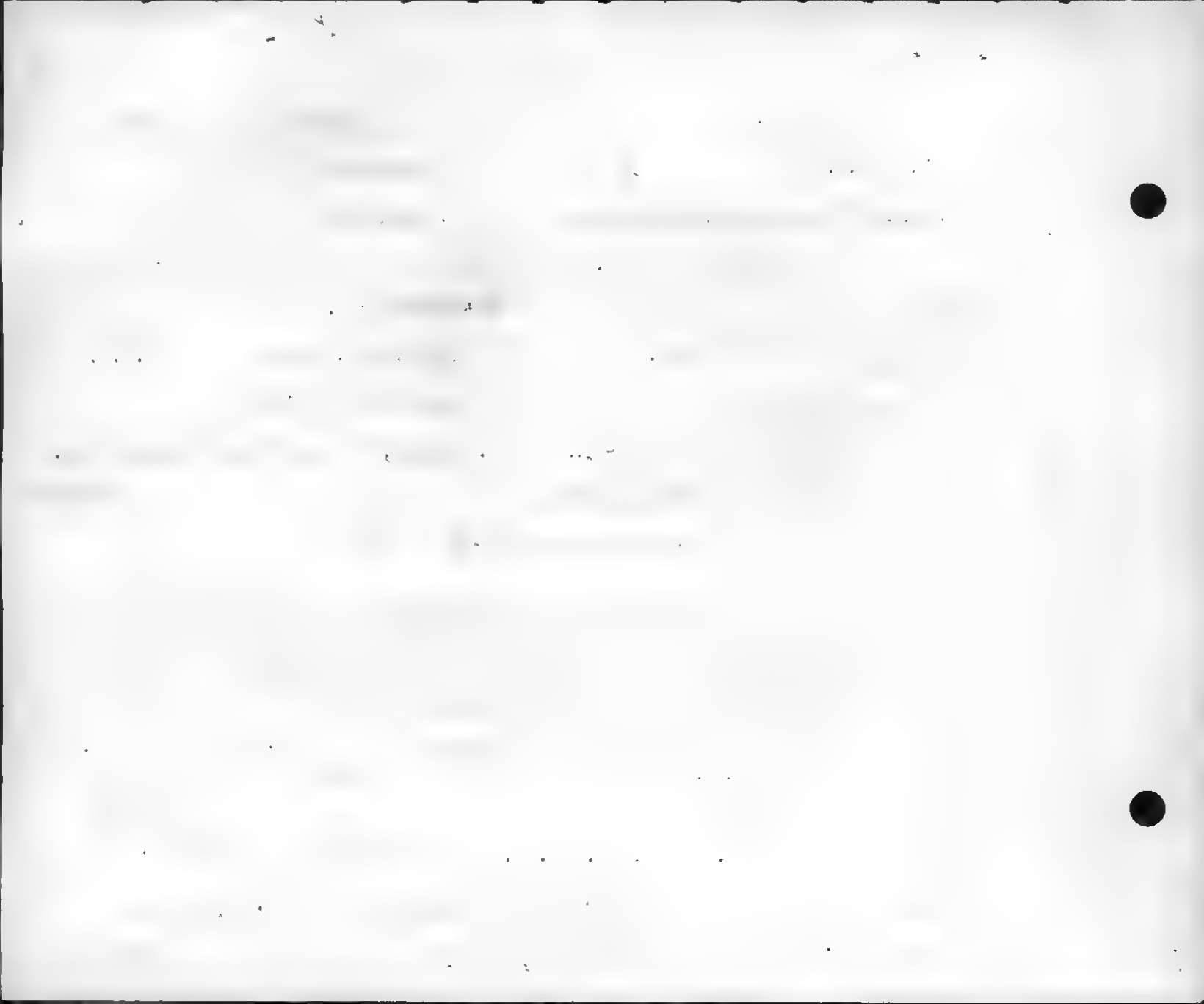
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b> c. LENGTH OF STAY IN 1b <b>52 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CARROLL</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>WESTMINSTER</b> d. STREET ADDRESS <b>74 HOOK ROAD</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>M.</b> Last <b>PENCE</b>		4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>10</b> Year <b>1966</b>	
5. SEX <b>MALE</b> 6. COLOR OR RACE <b>WHITE</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>FEBRUARY 28, 1895</b> 9. AGE (In years last birthday) <b>70</b> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>FARM</b>		11. BIRTHPLACE (County & State, or foreign country) <b>TIMBERVILLE, VIRGINIA</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CASPER PENCE</b>		14. MOTHER'S MAIDEN NAME <b>MARY FRANCES ANDRICK</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> (If yes give war or dates of service) <b>WW I</b>		16. SOCIAL SECURITY NO. <b>220-14-2515</b> 17. INFORMANT <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> <b>4500</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH <b>30 MINUTES</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from <b>11/29/65</b> , 19__, to <b>2/10/66</b> , 19__, that (we) last saw the deceased alive on <b>2/10/66</b> , 19__, and that death occurred at <b>8:30 AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Lawrence F. Awalt, Jr.</b> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>2/10/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>LAWRENCE F. AWALT, JR., M. D.</b>		22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>2/13/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>PLEASANT VALLEY CEMETERY WESTMINSTER, MARYLAND</b>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR <b>J. E. Myers, Jr.</b>		25a. REC'D BY REGISTRAR <b>FEB 14 1966</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02022

01969

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonville</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1507 Frederick Road</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonville</u> d. STREET ADDRESS <u>1507 Frederick Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) <u>EARL</u> First <u>GARFIELD</u> Middle <u>PERKINS</u> Last		<b>4. DATE OF DEATH</b> Month <u>2</u> Day <u>19</u> Year <u>1966</u>		<b>5. SEX</b> <u>M</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>8-14-1881</u>		<b>9. AGE</b> (In years last birthday) <u>84</u> yrs. IF UNDER 1 YEAR: Months <u>8</u> Days <u>4</u> IF UNDER 24 HRS: Hours <u>8</u> Min. <u>4</u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Superintendent Insurance Co.</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Ohio</u>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Ohio</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>US</u>			
<b>13. FATHER'S NAME</b> <u>William E. Perkins</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Nancy Beckett</u>									
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <u>214-03-6854</u>				<b>17. INFORMANT</b> <u>Kathryn P. Kriel</u> Address <u>1507 Frederick Rd - 28</u>							
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>A.S.C.V.D.</u> DUE TO (c)												<b>19. INTERVAL BETWEEN ONSET AND DEATH</b> <u>10 mins.</u>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>														<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)						<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)									
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>8:00</u> Hour a.m. <u>Feb 19 1966</u> p.m.				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		<b>20a. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20i. (City or town)</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>JULY</u> <u>1964</u> <b>to</b> <u>PRESENT</u> , <u>19</u> ....., <b>that (I) (we) last saw the deceased alive on</b> <u>Feb</u> <u>19</u> ....., <b>and that death occurred at</b> <u>8 A.M.</u> <b>from the causes and on the date stated above.</b>															
<b>22a. SIGNATURE</b> <u>[Signature]</u>						<b>M.D.</b>		<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>Feb 19 1966</u>					
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>WATSON KIME</u>						<b>22d. ADDRESS</b> <u>1010 ST. PAUL ST. BALT. Md.</u>									
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b>				<b>23b. DATE THEREOF</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b>				<b>23d. LOCATION (City, town or county) (State)</b>					
<u>Entombment</u>				<u>2-22-1966</u>		<u>Lorraine Mausoleum</u>				<u>Woodlawn-Balti Co - Md</u>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>E. S. MacNabb</u>						<b>ADDRESS</b> <u>3017 Frederick Rd - 21228</u>		<b>25a. REC'D BY REGISTRAR</b> <u>FEB 23 1966</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE HEALTH DEPT.

02023

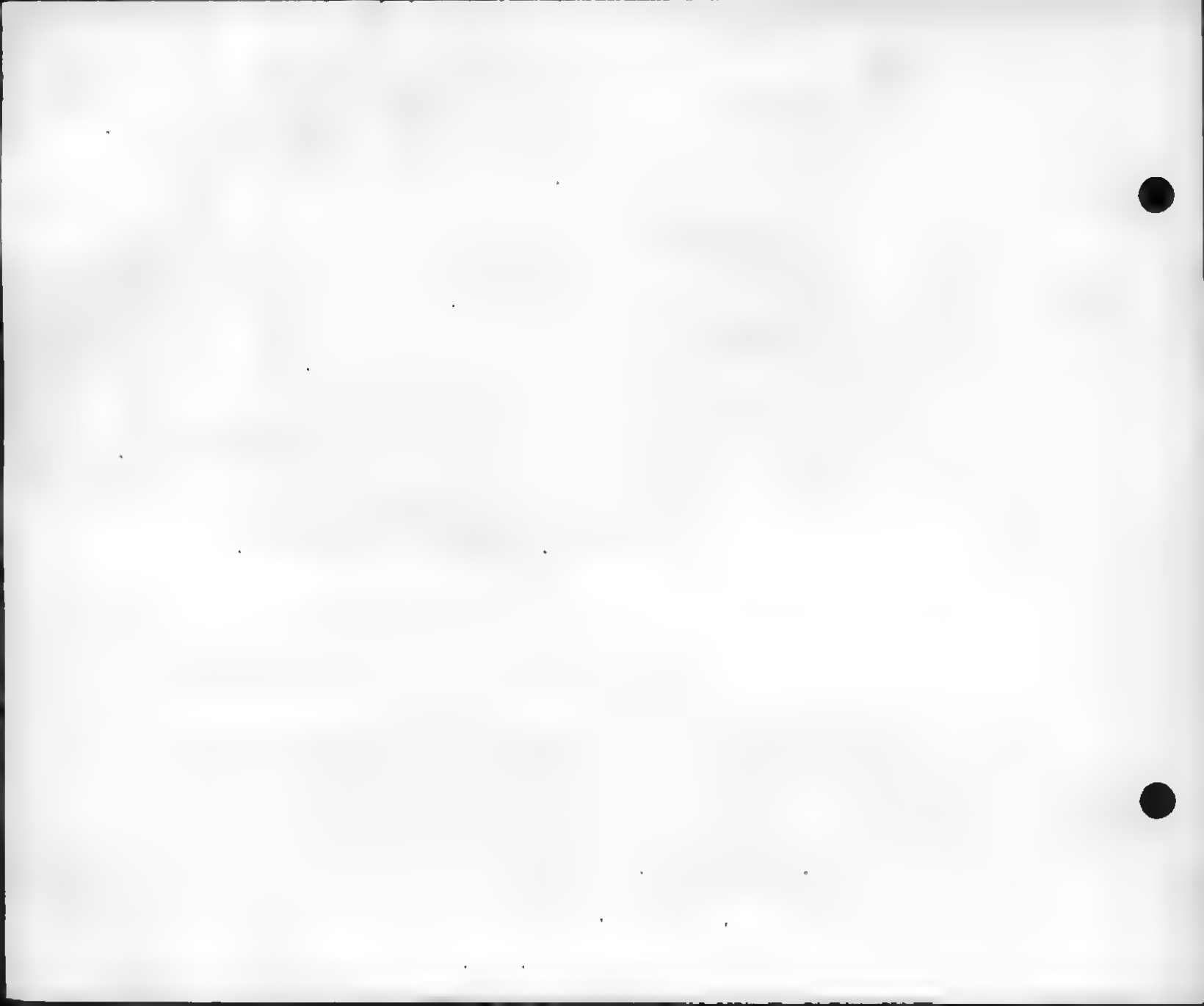
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01370

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiners Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Randallstown</b>		c. LENGTH OF STAY N 1b <b>1/2 hr.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Baltimore Co. General Hospital</b>		e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore 7</b>	
f. STREET ADDRESS <b>Rices Lane</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Patrick</b> Middle <b>Joseph</b> Last <b>Perry</b>		4 DATE OF DEATH Month <b>Feb.</b> Day <b>26</b> Year <b>1966</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>July 27, 1949</b>
9 AGE (In years last birthday) <b>16</b> yrs		10 IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min <b>1</b>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>INDUSTRY</b>	
12 BIRTHPLACE (State or foreign country) <b>Balto. Co., Md.</b>		13 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14 FATHER'S NAME <b>Joseph Perry</b>		15 MOTHER'S MAIDEN NAME <b>Thelma Whalen</b>	
16 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		17 SOC. A. SEC. NO. <b>none</b>	
18 INFORMANT <b>Mr. Joseph Perry, Rices Lane, Balto. 7, Md.</b>		Address	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Fractures of lower jaw; Fracture base of skull;</b> DUE TO <b>Compound fract. lower 1/3 of Rt. Femur;</b> (and trans if any, which gave rise to immediate cause (a), stating the underlying cause last.) (b) <b>Compound fract. w/ avulsion of rt. thumb.</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Car ran off rd., struck pole &amp; then fire hydrant.</b>	
20c. TIME OF INJURY Month Day, Year <b>3:31</b> Hour <b>3:31</b> pm <b>Feb. 26</b> 1966		20d. INJURY OCCURRED <input type="checkbox"/> While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Dogwood Rd.</b>		20f. (City or town) (County) (State) <b>Balto. 7 Balto. Md.</b>	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>D. D. Caples</b> EXAMINER'S NAME (Type) <b>D. D. Caples, M. D.</b>		22. DATE SIGNED <b>2-28-66</b>	
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>March 2, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d. LOCATION (City or town) (County) (State) <b>Baltimore, Maryland</b>	
24 FUNERAL DIRECTOR <b>Ellsworth Armacost-4600 Liberty Hgts. Ave.</b>		25a. REC'D BY REGISTRAR <b>DATE MAR 1 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



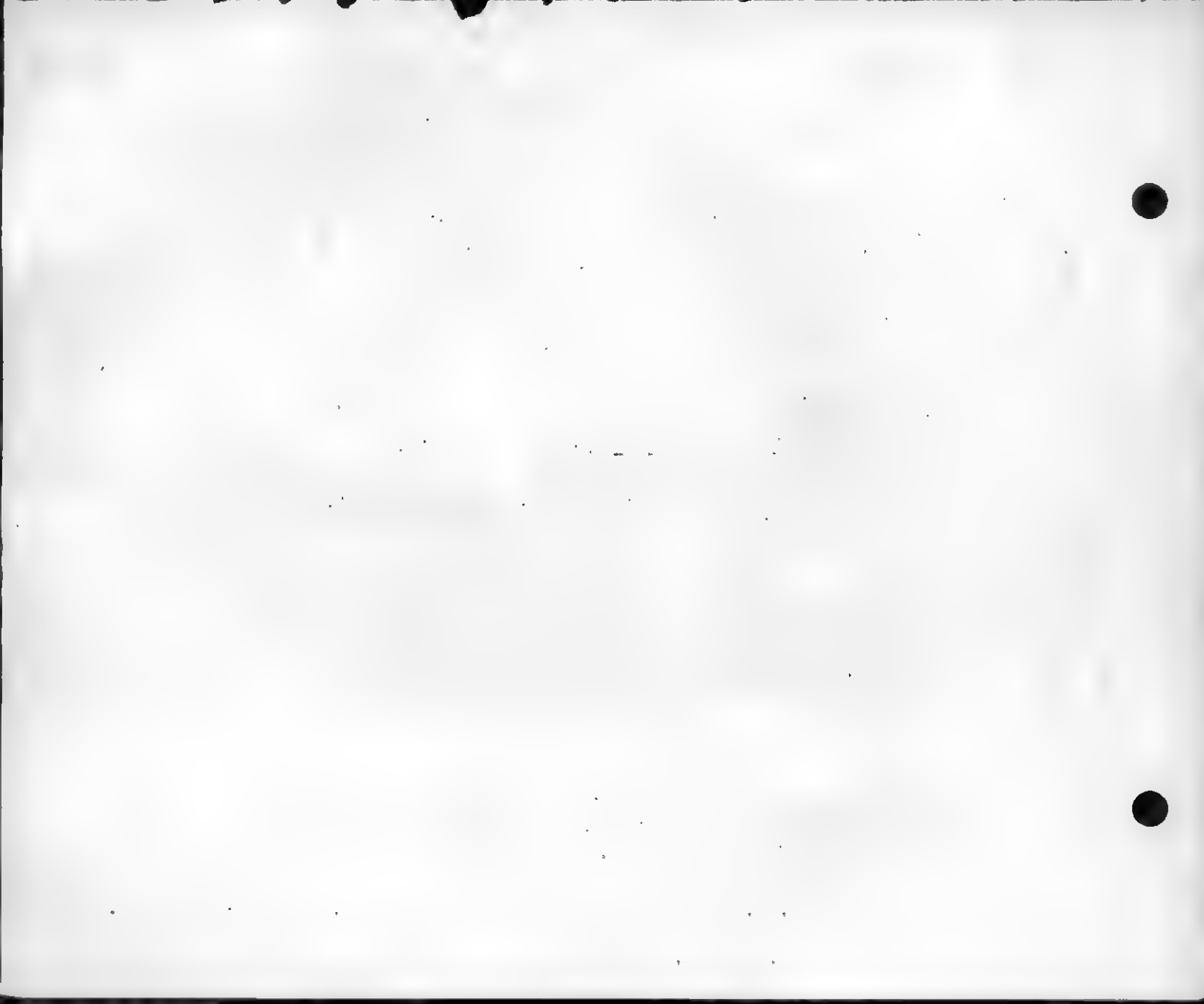
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Towson</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>St. Joseph's Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Towson</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Towson</b> d. STREET ADDRESS <b>1429 Jeffers Rd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Audrey D. Philipp</b>		4. DATE OF DEATH Month <b>February</b> Day <b>26</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 10, 1916</b>
9. AGE (in years last birthday) <b>49</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>1</b> Days <b>16</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Post Office</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>	
13. FATHER'S NAME <b>Raymond Collier</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Gaunt</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-01-1630</b>	
17. INFORMANT <b>Family Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis from adenocarcinoma of left breast</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DUE TO</b> (c) <b>DUE TO</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office/bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Feb. 15</b> , 1966, to <b>Feb. 26</b> , 1966, that (I) (we) last saw the deceased alive on <b>Feb. 26</b> , 1966, and that death occurred at <b>2:05 A.M.</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>William Wilkie, M.D.</b>		22b. DATE SIGNED <b>Feb. 26, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>William Wilkie, M.D.</b>		22d. ADDRESS <b>7620 York Road, 21204</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Mar. 1, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley Memorial Cns.</b>		23d. LOCATION (City, town or county) (State) <b>Cockeysville, Md.</b>	
24. FUNERAL DIRECTOR <b>John Burns' Sons, Towson, Maryland</b>		25a. RECEIVED BY REGISTRAR <b>MAR 2 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

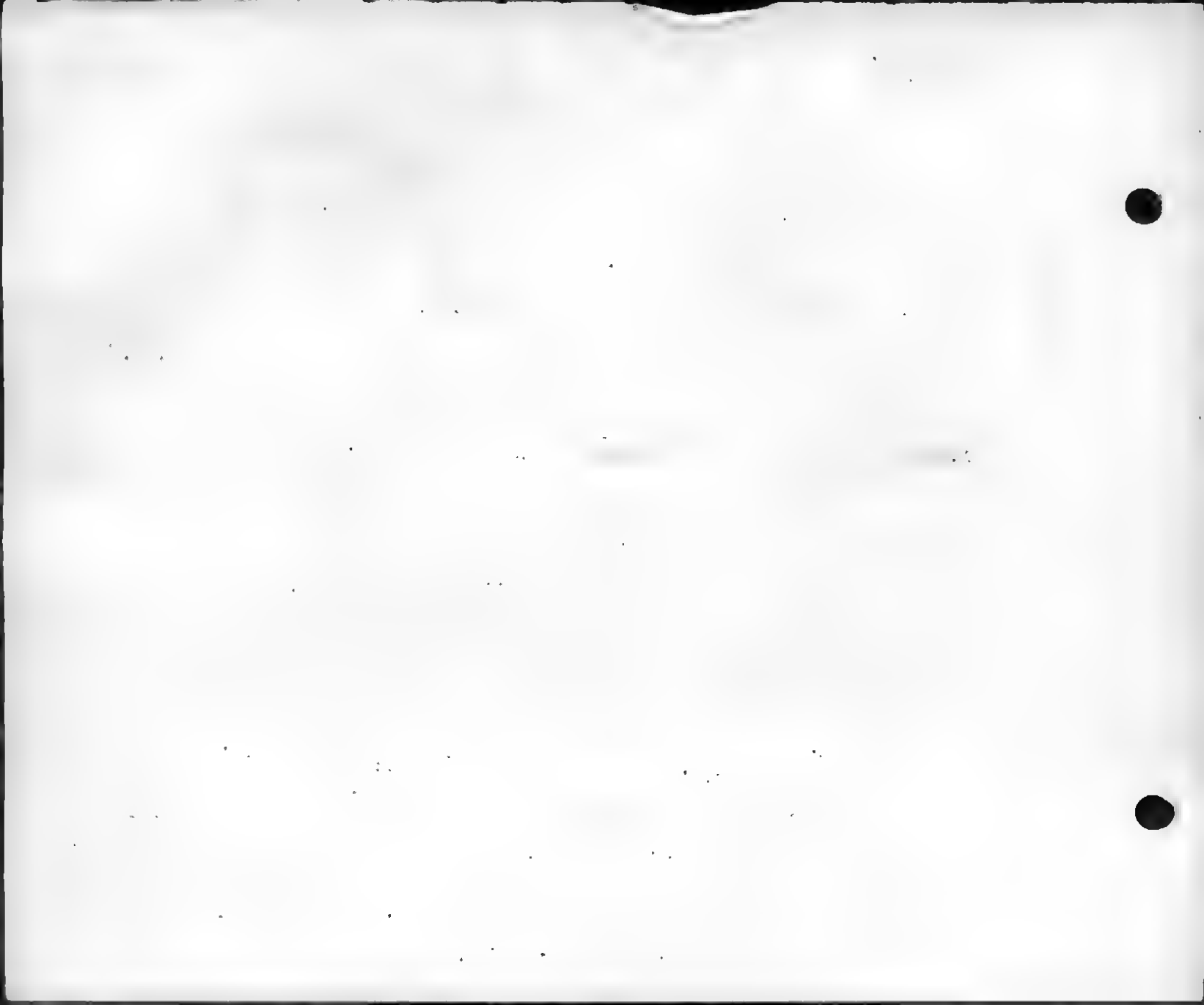


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. There please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02025		01972	
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN ID <b>3yr3mth17days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>3602 Reisterstown Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>C.</b> Last <b>Plank</b>		4. DATE OF DEATH Month <b>February</b> Day <b>1</b> Year <b>1966</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 9, 1882</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>saleslady</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>83</b> yrs. IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Andrew Spies</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Yeakel</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>215-10-7118</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Dehydration and malnutrition</b> DUE TO (c) <b>Generalized arteriosclerosis, severe</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from <b>Oct. 11, 1962</b> , to <b>Feb. 1, 1966</b> , that (we) last saw the deceased alive on <b>Feb. 1, 1966</b> , and that death occurred at <b>11:55</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Stella Wachslar</b> M.D.		22b. DATE SIGNED <b>2-2-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>		22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/5/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Balto.</b>	
24. FUNERAL DIRECTOR <b>Mitchell-Wiedefeld Home-6500 York Rd. 12</b>		25a. REC'D BY REGISTRAR <b>FEB 8 1966</b>	
25b. REGISTRAR'S SIGNATURE			



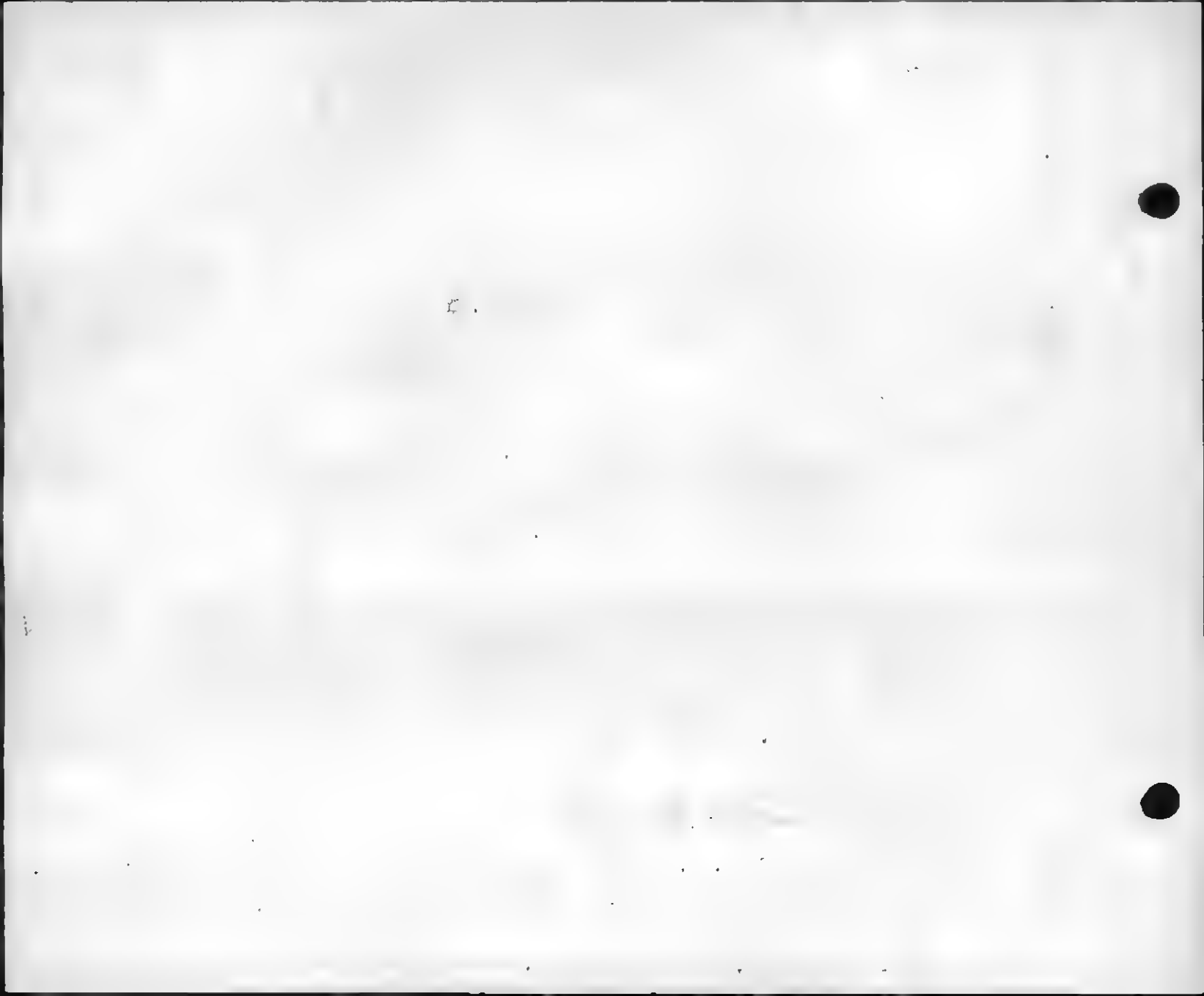
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

VR A15ME  
3500 4-64

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
02026 Item 77 Film #0313 2/21/66									
01973									
1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE HIGHLANDS</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>2606 VIRGINIA AVENUE 21227</b>					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE HIGHLANDS</b> d. STREET ADDRESS <b>2606 VIRGINIA AVENUE 21227</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>ANN</b> Last <b>PREUHS</b>					4. DATE OF DEATH Month <b>2</b> Day <b>11</b> Year <b>19 66</b>				
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>FEB. 6, 1903</b>		9. AGE (in years last birthday) <b>63</b> yrs. IF UNDER 1 YEAR: Months <b>11</b> Days <b>19</b> IF UNDER 24 HRS: Hours <b>66</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13. FATHER'S NAME <b>MICHAEL PRIVARA</b>					14. MOTHER'S MAIDEN NAME <b>ANNA GALKA</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service)			16. SOCIAL SECURITY NO. <b>220-09-0813</b>		17. INFORMANT <b>MR. LEON MAJKA,</b>		Address <b>2606 VIRGINIA AVE.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4-2-21 Cerebral Accident</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Arterio sclerotic, Cardio vascular Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>George S. M. Kieffer</b> EXAMINER'S NAME (Type) <b>GEORGE S. M. KIEFFER</b>					CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>L-11-66</b> Address (Street, city, town, or county) <b>1010 LEEDS AVE.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE THEREOF <b>2/14/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LOUDON PARK CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>BALTO., MD.</b>		
24. FUNERAL DIRECTOR <b>HUBBARD FUNERAL HOME, 4107 WILKENS AVE. 21229</b>					25a. REC'D BY REGISTRAR <b>FEB 16 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. J. Judge</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
02027 CERTIFICATE OF DEATH 01974

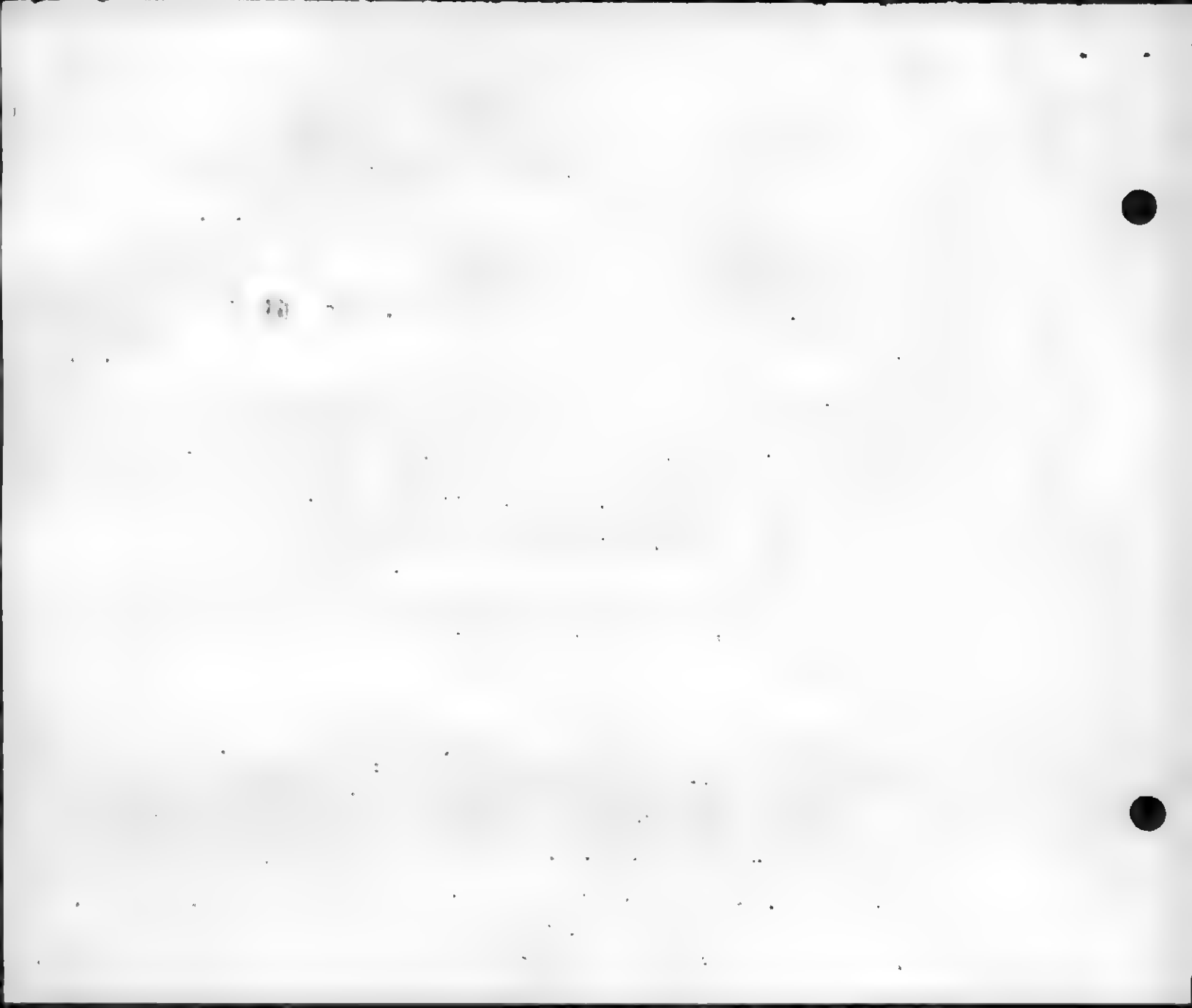
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mount Wilson</b>		c. LENGTH OF STAY, in 1b <b>5 mo. 7 days</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Queen Anne's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Queenstown</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Mount Wilson State Hospital</b>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <b>EDNA - ANN-HIGDON-PRICE</b>		First Middle Last		4. DATE OF DEATH Month Day Year <b>2 3 1966</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>7.18.1905</b>	9. AGE (In years last birthday) <b>60</b> yrs.	10. FUND 1 YEAR Months Days Hours Mins.	11. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>FRANK HIGDON</b>				14. MOTHER'S MAIDEN NAME <b>WINNIE CLIFTON</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-05-4681</b>		17. INFORMANT Address <b>Hospital Records, Mt. Wilson State Hosp.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral vascular accident</b> <b>1124</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>Embolus from carcinoma of endometrium</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Far advanced pulmonary tuberculosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>8 hrs</b> <b>5 years</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>8.27.1965</b> to <b>2.3.1966</b> , that (I) (we) last saw the deceased alive on <b>2.3.1966</b> , and that death occurred at <b>4:30</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Wm. Newcomer</b>		M.O. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2.3.1966</b>			
22c. PHYSICIAN'S NAME (Type) <b>Wm. Newcomer, M.D., Superintendent</b>		22d. ADDRESS <b>Mount Wilson, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>Feb. 7, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Chesterfield Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Centerville, Maryland</b>	
24. FUNERAL DIRECTOR <b>James H. Butler, Jr., Centerville, Md.</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>FEB 14 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>1yr4mth9dys</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince George's</b>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>					e. STREET ADDRESS <b>204 Oneida Way - S. E.</b>			f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF (Type or print) <b>Sue</b>			First Middle Last <b>Raines</b>			4. DATE OF DEATH <b>February 1 19 66</b>		Month Day Year		
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 18, 1879</b>		9. AGE (In years last birthday) <b>86</b> s. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Iowa</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		
13. FATHER'S NAME <b>Volney Beeson</b>					14. MOTHER'S MAIDEN NAME <b>Josephine Morgan</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>				16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pulmonary emboli; right lower lobe</b> <b>466x</b> OUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Thrombosis of left iliac vein</b> OUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Comminuted, intertrochanteric fracture; left femur</b>								INTERVAL BETWEEN ONSET AND DEATH		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office/bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Sept. 22 1964</b> to <b>Feb. 1, 1966</b> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <b>Feb. 1 1966</b> , and that death occurred at <b>8:55</b> M, from the causes and on the date stated above.										
22a. SIGNATURE <b>Stella Wachslar</b>					M.O. ATTENDING PHYS. <input checked="" type="checkbox"/>		MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2-1-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>					22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 3-1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Bladensburg, Maryland.</b>				
24. FUNERAL DIRECTOR <b>Simmons Bros Wash DC 20020</b>					25a. REC'D BY REGISTRAR <b>FEB 7 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



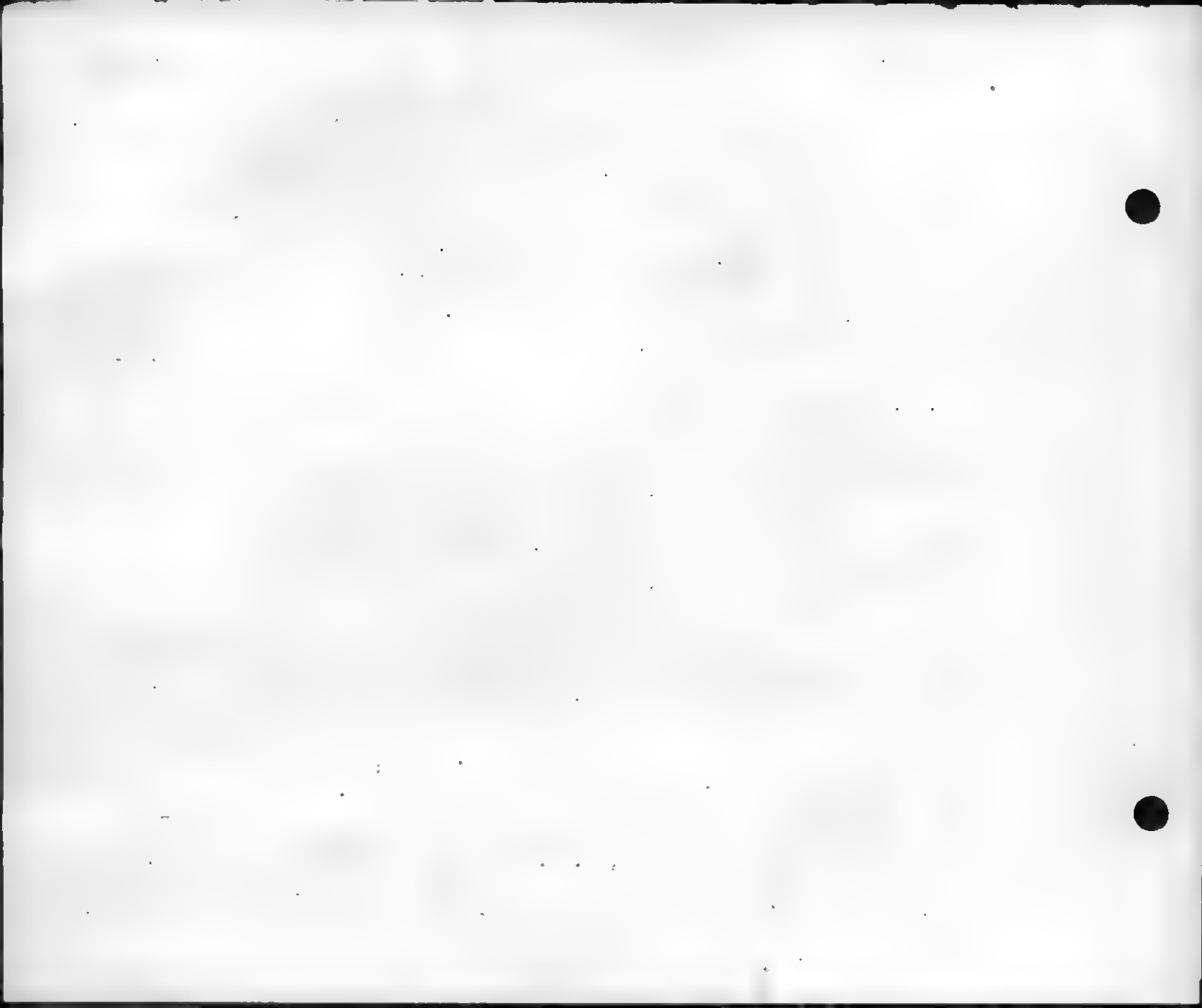
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN 1b <b>5mth16dys</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Parkton, Maryland</b> d. STREET ADDRESS <b>Foreston Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Marie</b> Middle <b>Rambo</b> Last 4. DATE OF DEATH <b>February 4 19 66</b>		5. SEX <b>female</b> 6. COLOR OR RACE <b>white</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <b>Sept. 20, 1891</b> 9. AGE (in years last birthday) <b>74</b> yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b> 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) <b>Georgia</b> 12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		13. FATHER'S NAME <b>H. L. McDonald</b> 14. MOTHER'S MAIDEN NAME <b>Orienda Bowen</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b> (If yes give war or dates of service) 16. SOCIAL SECURITY NO. <b>unknown</b> 17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> DUE TO (b) <b>Generalized arteriosclerosis, severe</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that <del>the</del> (this hospital) attended the deceased from <b>Aug. 28 19 65</b> to <b>Feb. 4 19 66</b> , that <del>he</del> (we) last saw the deceased alive on <b>Feb. 4 19 66</b> , and that death occurred at <b>11:15</b> M, from the causes and on the date stated above.	
22a. SIGNATURE <b>Stella Wachslar</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <b>2-4-66</b>		22c. PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b> 22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</b>	
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>Removal</b> 23b. DATE THEREOF <b>2/4/66</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Southern Mem. PK. Cmt. Miami, Fla</b> 23d. LOCATION (City, town or county) (State)		24. FUNERAL DIRECTOR <b>Wm. J. Tickner-Sono North Pa.</b> ADDRESS <b>Baltimore, Md.</b> 25a. REC'D BY REGISTRAR <b>FEB 4 1966</b> 25b. REGISTRAR'S SIGNATURE <b>Wm. J. Tickner-Sono</b>	



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

02030

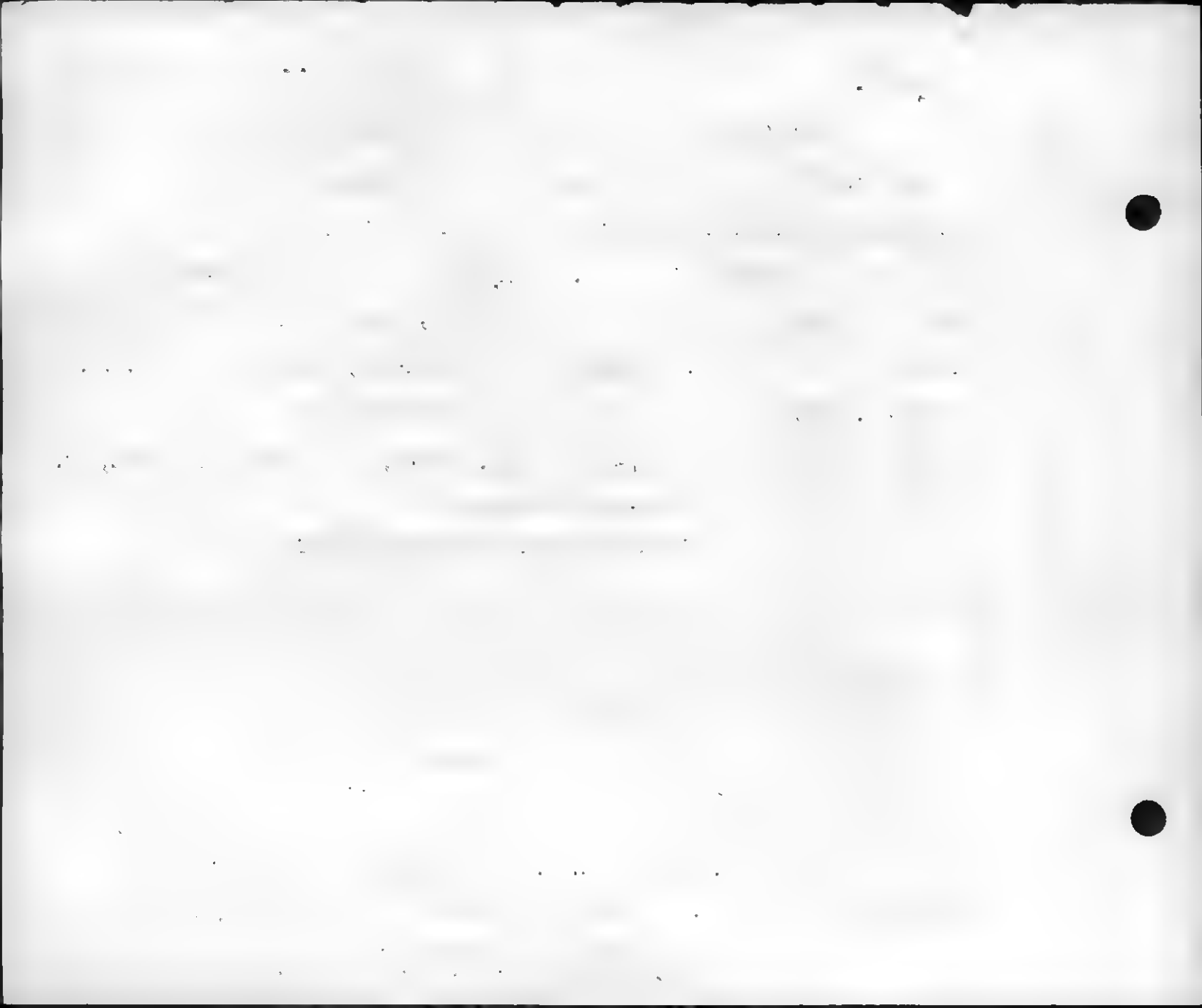
01077

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b></b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>				c. LENGTH OF STAY IN 1b <b>3 DAYS</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>			
f. STREET ADDRESS <b>2202 KENTUCKY AVENUE</b>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>L.</b> Last <b>RASCH</b>		4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>15</b> Year <b>19 66</b>		5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>MAY 19, 1889</b>		9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR: Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>REALTOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>REAL ESTATE</b>		11. BIRTHPLACE (County & State, or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN L. RASCH</b>				14. MOTHER'S MAIDEN NAME <b>MARGARET ITZEL</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW I</b>		16. SOCIAL SECURITY NO. <b>215-07-0655</b>		17. INFORMANT <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> 4 over 1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO (c) <b></b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>							INTERVAL BETWEEN ONSET AND DEATH <b></b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <b></b> a.m. <b></b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (he/she) attended the deceased from <b>2/12/66</b> , 19 <b></b> , to <b>2/15/66</b> , 19 <b></b> , that (he/she) last saw the deceased alive on <b>2/15/66</b> , 19 <b></b> , and that death occurred at <b>4:45 AM</b> from the causes and on the date stated above.							
22a. SIGNATURE <i>William B. Kingree</i>				22b. DATE SIGNED <b>2/15/66</b>		22c. PHYSICIAN'S NAME (Type) <b>WILLIAM B. KINGREE, M. D.</b>	
22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>2/18/66.</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>		23d. LOCATION (City, town or county) (State) <b>BALTIMORE, MARYLAND</b>	
24. FUNERAL DIRECTOR <b>LEONARD RUCK FUNERAL HOME</b>				25a. REC'D BY REGISTRAR <b>FEB 16 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

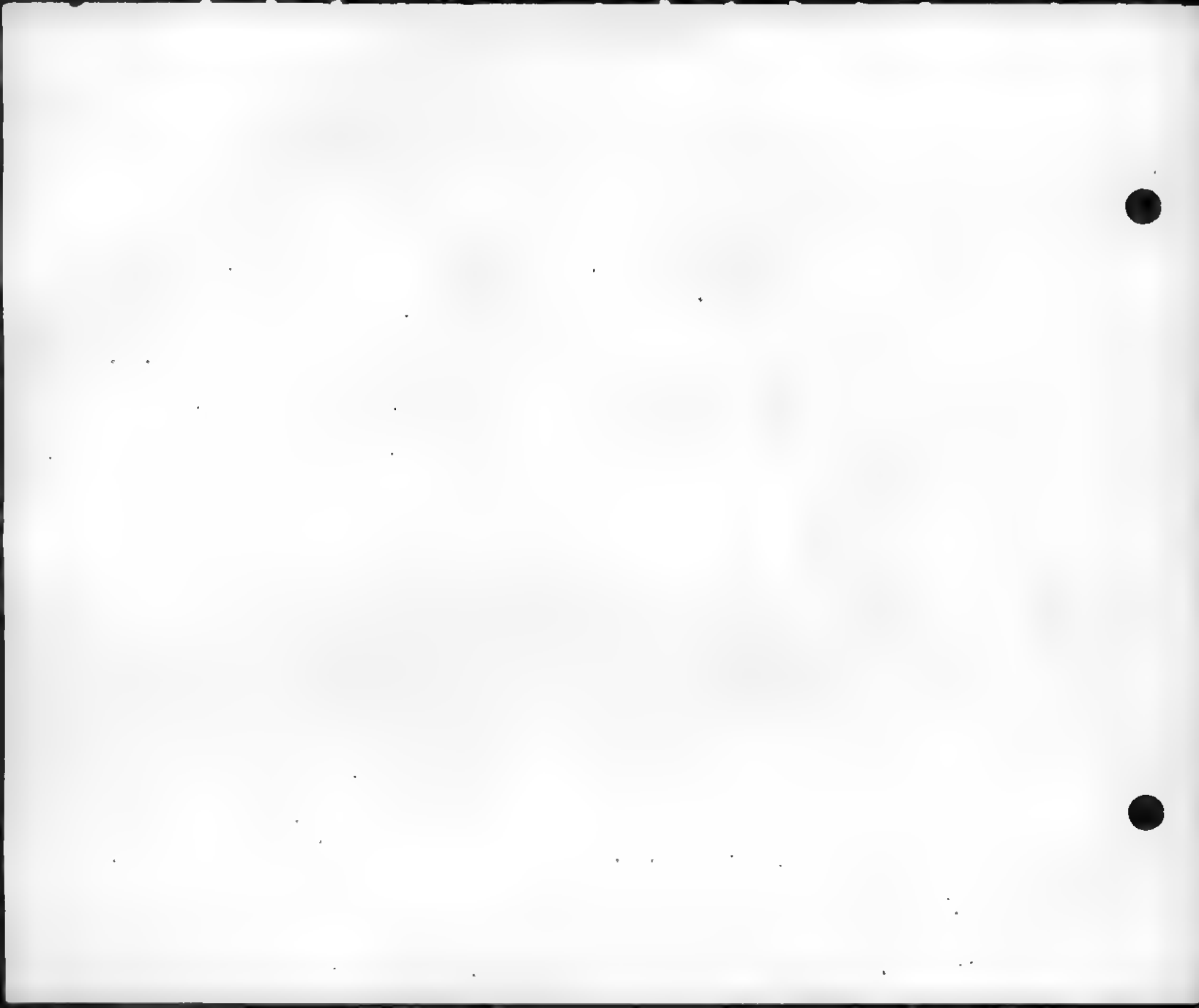
VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02031

01078

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Howard</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>1yr3mth20dys</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkridge</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>				d. STREET ADDRESS <b>Box 298</b>	
3. NAME OF DECEASED (Type or print) <b>Andrew M. Rawlings</b>		4. DATE OF DEATH <b>Feb. 24 1966</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 28, 1913</b>	9. AGE (In years birth day) <b>52 yrs.</b>	IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS: Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		13. FATHER'S NAME <b>Marshall Rawlings</b>		14. MOTHER'S MAIDEN NAME <b>Emma Thompson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>216-07-9161</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PNEUMONIA -</b> <b>475X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>475X</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>21X CNS Syphilis</b>					
19. INTERVAL BETWEEN ONSET AND DEATH <b>DAYS</b>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <b>11-4-66</b> to <b>2-24-66</b> , that (I) (we) last saw the deceased alive on <b>2-24-66</b> , and that death occurred at <b>3:4</b> M, from the causes and on the date stated above.					
22a. SIGNATURE <b>George Rodon</b>		22b. DATE SIGNED <b>2-24-66</b>		22c. PHYSICIAN'S NAME (Type) <b>George Rodon, M. D.</b>	
22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL</b>		22e. ADDRESS <b>Baltimore, Maryland 21228</b>		22f. ADDRESS <b>Baltimore, Maryland 21228</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/27/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Stevens</b>	
23d. LOCATION (City, town or county) <b>Meadowridge Md.</b>		23e. LOCATION (City, town or county) <b>Meadowridge Md.</b>		23f. LOCATION (City, town or county) <b>Meadowridge Md.</b>	
24. FUNERAL DIRECTOR <b>Arlington S. Phillips</b>		24a. ADDRESS <b>1727 N. Monmouth</b>		24b. ADDRESS <b>1727 N. Monmouth</b>	
25a. REC'D BY REGISTRAR <b>2 MAR 2 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. M. Jones</b>		25c. REGISTRAR'S SIGNATURE <b>J. M. Jones</b>	

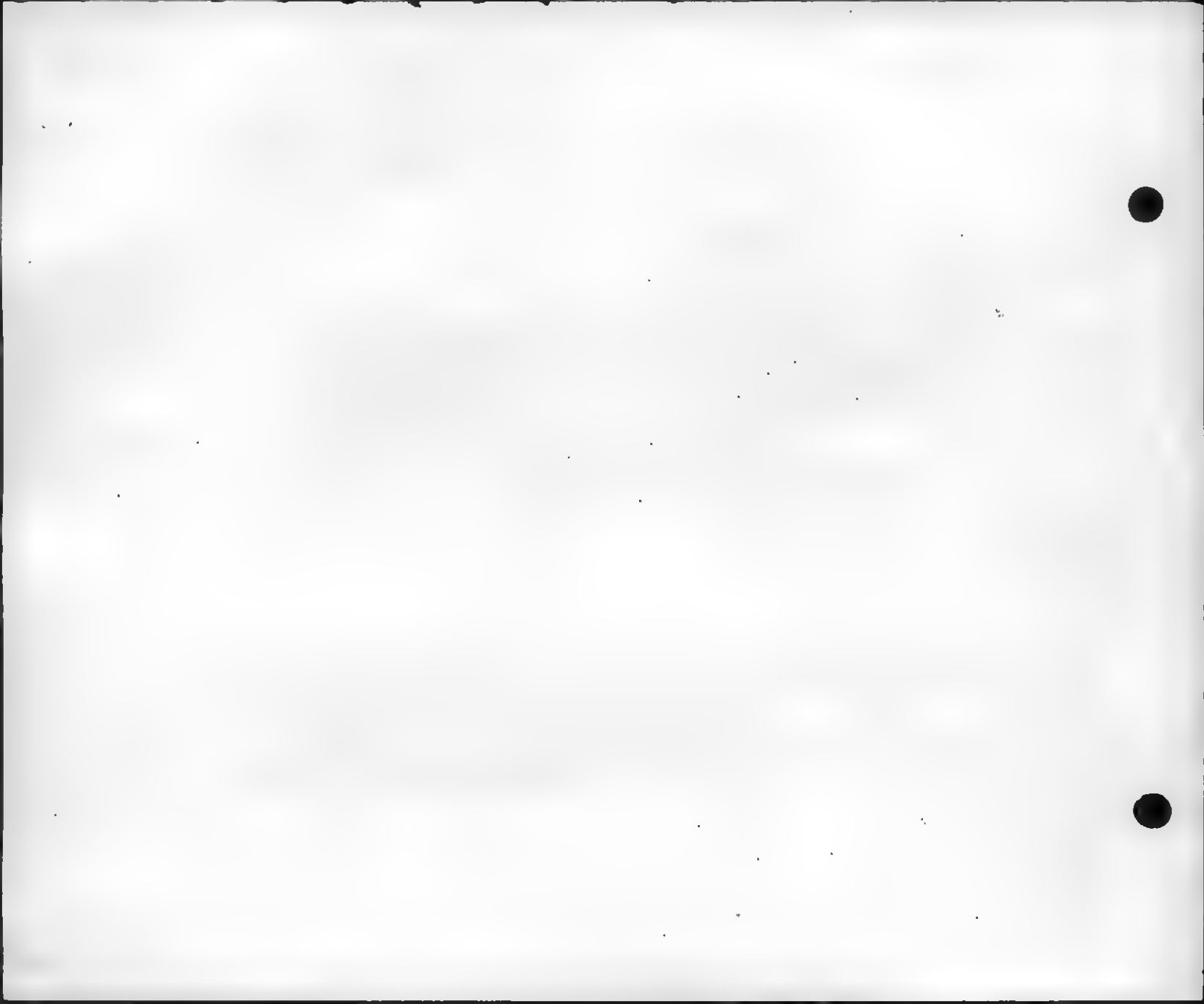


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
02032 CERTIFICATE OF DEATH 01579

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TOWSON, 21214</u> c. LENGTH OF STAY IN 1b <u>14 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>GREATER Baltimore Medical Center</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE 21211</u> d. STREET ADDRESS <u>4054 Hickory Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Hilda</u>		First <u>L</u> Middle <u>E</u> Last <u>Reed</u>		4. DATE OF DEATH Month <u>2</u> Day <u>12</u> Year <u>1966</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>7-11-1921</u>		9. AGE (In years last birthday) <u>44</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>7</u> Days <u>7</u> Hours <u>7</u> Min.			
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. MOTHER'S MAIDEN NAME <u>Myrl A. Wilhelm</u>			
14. MOTHER'S MAIDEN NAME <u>Myrl A. Wilhelm</u>		15. SOCIAL SECURITY NO. <u>22003 9603</u>		16. INFORMANT <u>Cherry E. Reed</u> Address <u>4054 Hickory</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____			
20f. (City or town) _____ (County) _____ (State) _____		21. I certify that (I) (this hospital) attended the deceased from <u>1/16</u> , 19 <u>66</u> , to <u>2/11</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2/11</u> , 19 <u>66</u> , and that death occurred at <u>11</u> M, from the causes and on the date stated above.					
22a. SIGNATURE <u>John F. Adams MD</u>		22b. DATE SIGNED _____		22c. PHYSICIAN'S NAME (Type) <u>John F. Adams MD</u>			
22d. ADDRESS _____		22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>16 Feb. 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lakeview Memorial Park</u>			
23d. LOCATION (City, town or county) <u>Balto., Md.</u>		23e. (State) _____					
24. FUNERAL DIRECTOR <u>Burgee Funeral Home, 3631 Falls Road</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>													
<b>1. PLACE OF DEATH</b> a. COUNTY <u>BALTIMORE</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>(RURAL) SPARKS</u> c. LENGTH OF STAY IN 1D <u>6 MONS.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>THORNTON MILL ROAD</u>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>(RURAL) SPARKS</u> d. STREET ADDRESS <u>THORNTON MILL ROAD</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) <u>FREDERICK C. REICHERT</u> First Middle Last				<b>4. DATE OF DEATH</b> <u>FEB. 5 1966</u> Month Day Year									
<b>5. SEX</b> <u>MALE</u>		<b>6. COLOR OR RACE</b> <u>WHITE</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>SEPT 29, 1872</u>		<b>9. AGE</b> (In years last birthday) <u>43</u> yrs.		<b>10. IF UNDER 1 YEAR</b> Months Days Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>FARMER (retired)</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>GEN. FARMING</u>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>FRANKFORD, GERMANY</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			
<b>13. FATHER'S NAME</b> <u>CONRAD REICHERT</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>ERNESTINE KUTT</u>							
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u>				<b>16. SOCIAL SECURITY NO.</b> <u>217-45-5161</u>		<b>17. INFORMANT</b> <u>EDWARD REICHERT</u> Address <u>21111 MONKTON, MD</u>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]													
<b>PART I. DEATH WAS CAUSED BY:</b>													
<b>IMMEDIATE CAUSE (a)</b> <u>Cardiac Failure</u>													
<b>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b>													
<b>DUE TO (b)</b> <u>Chronic Congestive Failure</u>													
<b>DUE TO (c)</b> <u>Arterio Sclerotic Cardio Vascular Disease</u>													
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>													
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)									
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. 19				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Jan</u> , 1962, to <u>2-5</u> , 1966, that (I) (we) last saw the deceased alive on <u>2-4</u> 1966, and that death occurred at <u>2:30</u> A.M. from the causes and on the date stated above.													
<b>22a. SIGNATURE</b> <u>C. Herbert Mueller</u>						<b>22b. DATE SIGNED</b> <u>2-5-66</u>							
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>C. HERBERT MUELLER, Jr.</u>						<b>22d. ADDRESS</b> <u>Paulton Md.</u>							
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>				<b>23b. DATE THEREOF</b> <u>2/8/1966</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>GOOD WILL</u>		<b>23d. LOCATION (City, town or county)</b> <u>ROTLIDGE MARYLAND</u>					
<b>24. FUNERAL DIRECTOR</b> <u>Charles E. Hunt Jarrett</u>						<b>25a. REC'D BY REGISTRAR</b> <u>1966</u>							
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Judge</u>													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

M

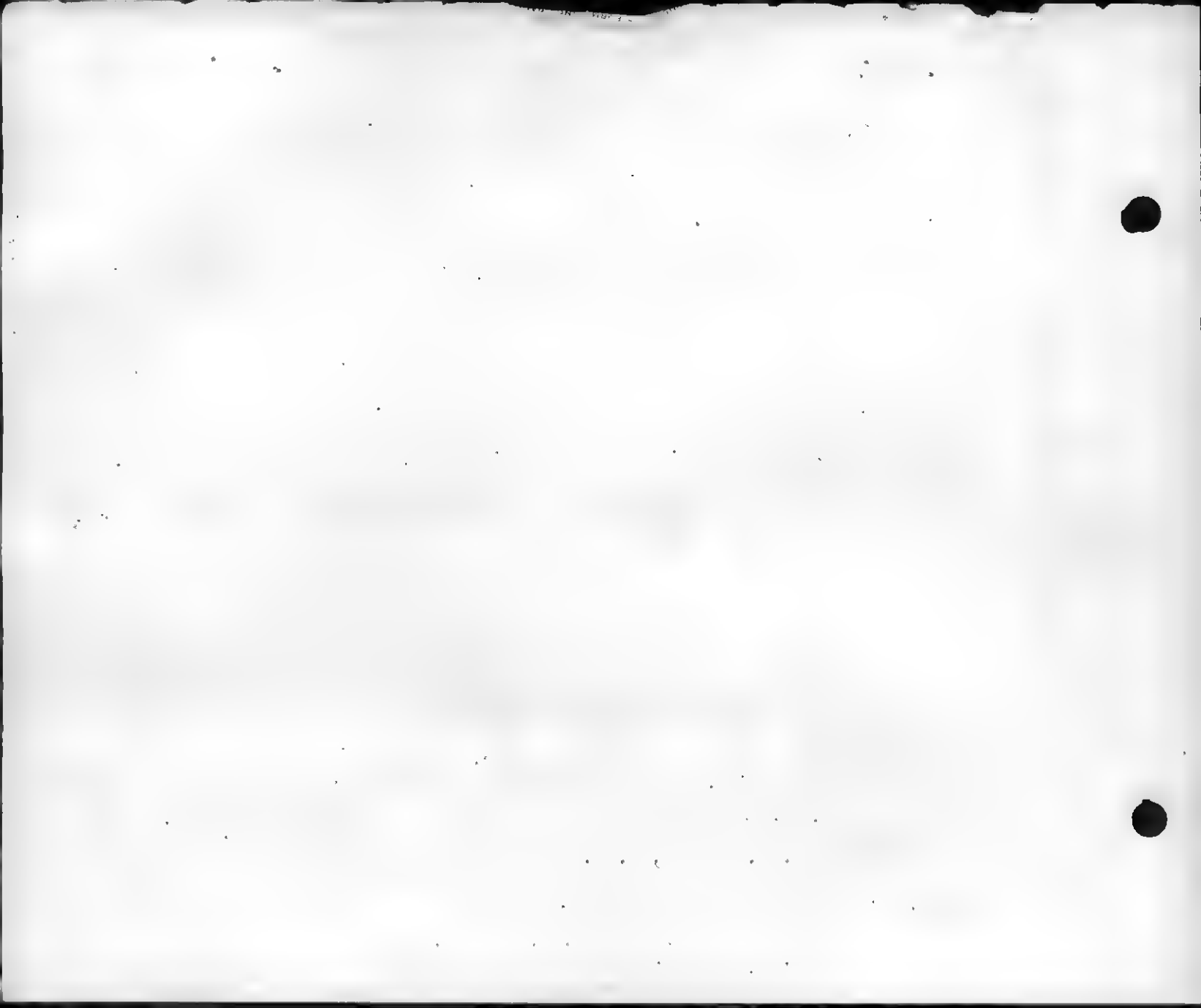
**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

02034

01081

<b>1. PLACE OF DEATH</b> <b>a. COUNTY</b> <p align="center"><b>BALTIMORE</b></p> <p align="center"><b>MARYLAND</b></p>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) <b>a. STATE</b> <p align="center"><b>MARYLAND</b></p> <p align="center"><b>b. COUNTY</b></p>									
<b>b. CITY OR TOWN</b> (If outside corporate limits, write RURAL and give nearest town) <p align="center"><b>FORT HOWARD</b></p>		<b>c. LENGTH OF STAY IN 1b</b> <p align="center"><b>63 DAYS</b></p>		<b>c. CITY OR TOWN</b> (If outside corporate limits, write RURAL and give nearest town) <p align="center"><b>BALTIMORE</b></p>									
<b>d. NAME OF HOSPITAL OR INSTITUTION</b> (if not in hospital, give street address) <p align="center"><b>VETERANS ADMINISTRATION HOSPITAL</b></p>				<b>d. STREET ADDRESS</b> <p align="center"><b>3562 JUNEWAY</b></p>		<b>e. IS RESIDENCE ON A FARM?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) <table style="width:100%; border: none;"> <tr> <td align="center" style="width:33%;">First <b>ROLAND</b></td> <td align="center" style="width:33%;">Middle <b>RUSSELL</b></td> <td align="center" style="width:33%;">Last <b>REYNOLDS</b></td> </tr> </table>				First <b>ROLAND</b>	Middle <b>RUSSELL</b>	Last <b>REYNOLDS</b>	<b>4. DATE OF DEATH</b> <table style="width:100%; border: none;"> <tr> <td align="center" style="width:33%;">Month <b>FEBRUARY</b></td> <td align="center" style="width:33%;">Day <b>22</b></td> <td align="center" style="width:33%;">Year <b>1966</b></td> </tr> </table>				Month <b>FEBRUARY</b>	Day <b>22</b>	Year <b>1966</b>
First <b>ROLAND</b>	Middle <b>RUSSELL</b>	Last <b>REYNOLDS</b>											
Month <b>FEBRUARY</b>	Day <b>22</b>	Year <b>1966</b>											
<b>5. SEX</b> <p align="center"><b>MALE</b></p>		<b>6. COLOR OR RACE</b> <p align="center"><b>WHITE</b></p>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <p align="center"><b>MARCH 9, 1919</b></p>							
<b>9. AGE</b> (In years last birthday) <p align="center"><b>46</b> yrs.</p>		<b>IF UNDER 1 YEAR</b> Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>		<b>IF UNDER 24 HRS.</b> Hours <input type="checkbox"/> Min. <input type="checkbox"/>		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <p align="center"><b>SALESMAN</b></p>							
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> 		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <p align="center"><b>BALTIMORE, MARYLAND</b></p>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <p align="center"><b>U.S.A.</b></p>		<b>13. FATHER'S NAME</b> <p align="center"><b>HARRY REYNOLDS</b></p>							
<b>14. MOTHER'S MAIDEN NAME</b> <p align="center"><b>LETTY BARLAG</b></p>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) YES <input checked="" type="checkbox"/> WW-11		<b>16. SOCIAL SECURITY NO.</b> <p align="center"><b>213 05 21 25</b></p>		<b>17. INFORMANT</b> <table style="width:100%; border: none;"> <tr> <td align="center" style="width:33%;">Address</td> <td style="width:66%;"></td> </tr> <tr> <td></td> <td align="center"><b>CLIN REC VET ADM HOSP FT HOWARD MARYLAND</b></td> </tr> </table>		Address			<b>CLIN REC VET ADM HOSP FT HOWARD MARYLAND</b>		
Address													
	<b>CLIN REC VET ADM HOSP FT HOWARD MARYLAND</b>												
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <b>METASTATIC SQUAMOUS CELL CARCINOMA TO LUMBAR SPINE</b> (b) <b>1762</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <p align="center"><b>8 MONTHS</b></p>							
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)</b>													
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)											
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input checked="" type="checkbox"/> <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>							
<b>21. I certify that</b> <input checked="" type="checkbox"/> (this hospital) <b>attended the deceased from</b> <b>Dec. 21, 1965, to Feb. 22, 1966</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Feb. 22, 1966</b> , and that death occurred at <b>10:42 P.M.</b> from the causes and on the date stated above.													
<b>22a. SIGNATURE</b> <p align="center"><i>F. I. Bloise</i></p>						<b>22b. DATE SIGNED</b> <p align="center"><b>2 23 66</b></p>							
<b>22c. PHYSICIAN'S NAME</b> (Type) <p align="center"><b>F. I. BLOISE, M. D.</b></p>				<b>22d. ADDRESS</b> <p align="center"><b>VET ADM HOSP FT HOWARD MARYLAND</b></p>									
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <p align="center"><b>BURIAL</b></p>		<b>23b. DATE THEREOF</b> <p align="center"><b>2-25-66</b></p>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <p align="center"><b>BALTIMORE NATIONAL</b></p>		<b>23d. LOCATION</b> (City, town or county) (State) <p align="center"><b>BALTIMORE MARYLAND</b></p>							
<b>24. FUNERAL DIRECTOR</b> <p align="center"><i>Leonard J. Ruck, Inc.</i></p>				<b>25a. REC'D BY REGISTRAR</b> <p align="center"><b>DATE FEB 25 1966</b></p>		<b>25b. REGISTRAR'S SIGNATURE</b> <p align="center"><i>Charles Judge</i></p>							

MEDICAL CERTIFICATION



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a separate certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE HEALTH DEPT.

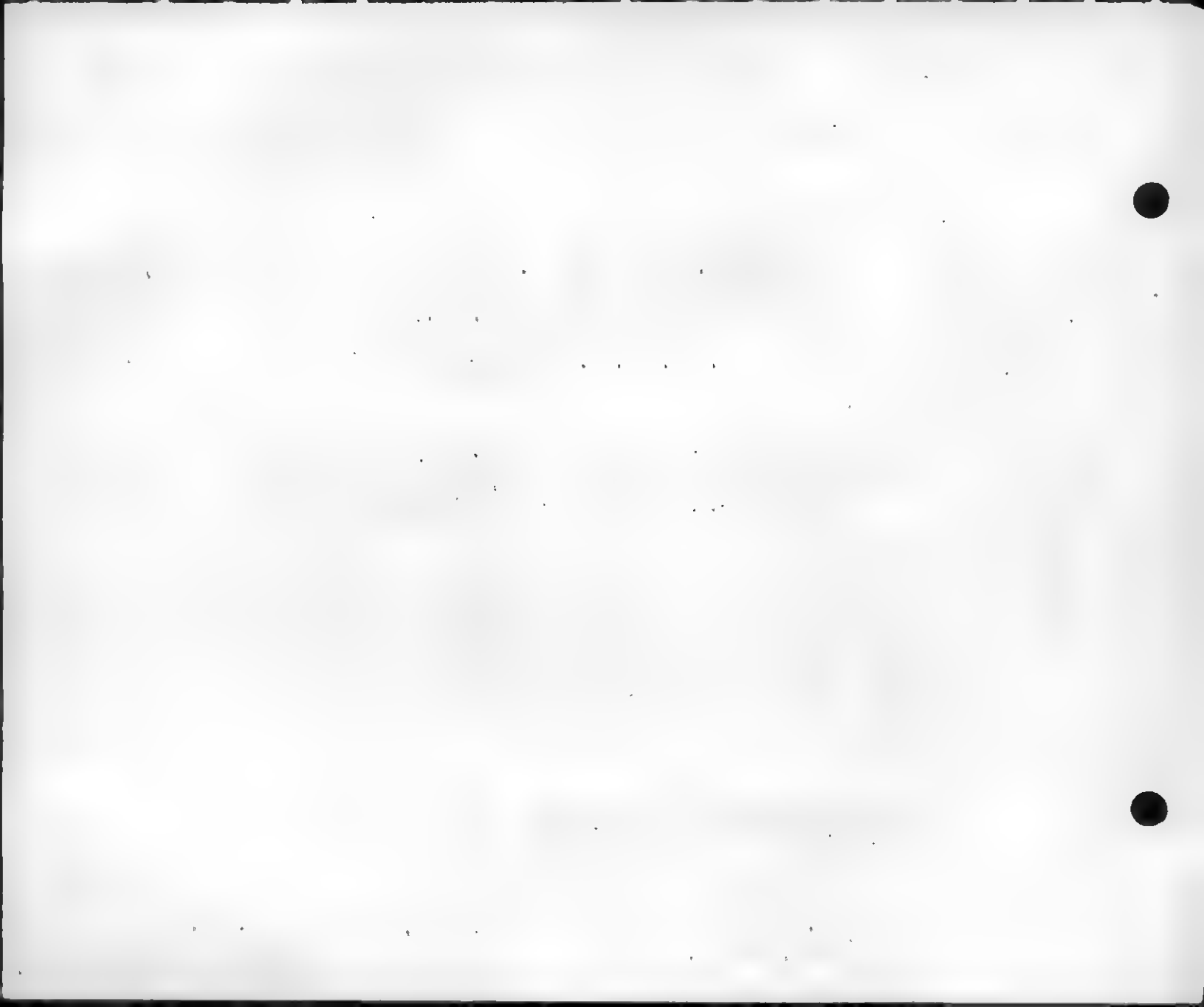
Items 20a-21 Film G374

02035

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01982

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>212 Willow Avenue</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u> d. STREET ADDRESS <u>212 Willow Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Walter W. Rice, Sr.</u>		4. DATE OF DEATH <u>February 11, 1966</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 19, 1916</u> 45 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B. &amp; D. Mfg. Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Rice</u>		14. MOTHER'S MAIDEN NAME <u>Louella</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>235-18-1740</u>	
17. INFORMANT <u>Family records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>gunshot wound of head</u> 976 X Conditions, if any, which gave rise to immediate cause (b) <u>Sudden</u> underlying cause (c) <u>Interval between onset and death</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY CAUSE OF CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>Placed double barrel shot gun in mouth and pulled trigger.</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>4:00</u> p.m. <u>2/11 1966</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Towson Balto. Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Charles F. Donald</u>		22. DATE SIGNED <u>2/11/66</u>	
EXAMINER'S NAME (Type)		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Feb. 16, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cem.</u>	23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Maryland</u>		25. REC'D BY REGISTRAR <u>FEB 16 1966</u> REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

# MARYLAND STATE DEPARTMENT OF HEALTH

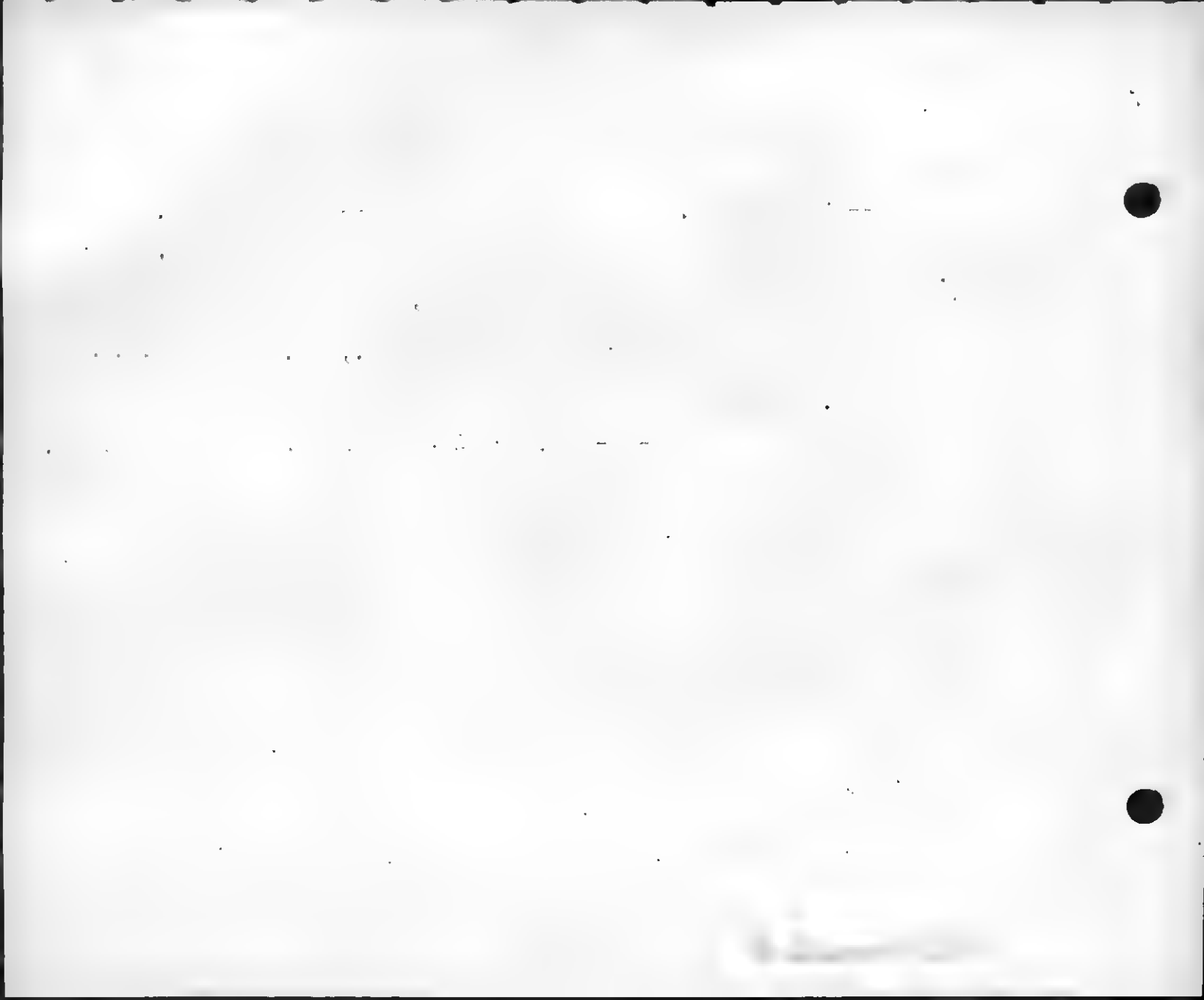
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02036

01983

<p>1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>White Marsh</b> c. LENGTH OF STAY IN 1b <b>yrs</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Box 16--Ebenezer Rd.</b></p>				<p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>White Marsh</b> d. STREET ADDRESS <b>Box 16-- Ebenezer Rd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>			
<p>3. NAME OF DECEASED (Type or print) <b>Benjamin Franklin Richardson</b> First Middle Last</p>				<p>4. DATE OF DEATH <b>Feb 22, 1966</b> Month Day Year</p>			
<p>5. SEX <b>Male</b> <b>XXXX</b></p>		<p>6. COLOR OR RACE <b>White</b></p>		<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <b>Sept 8, 1883</b></p>	
<p>9. AGE (In years last birthday) <b>82</b> yrs.</p>		<p>10. IF UNDER 1 YEAR Months Days</p>		<p>11. IF UNDER 24 HRS. Hours Min.</p>		<p>12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b></p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b></p>				<p>10b. KIND OF BUSINESS OR INDUSTRY <b>Self employed</b></p>		<p>11. BIRTHPLACE (County &amp; State, or foreign country) <b>Balt Co., Md.</b></p>	
<p>13. FATHER'S NAME <b>Wallis P. Richardson</b></p>				<p>14. MOTHER'S MAIDEN NAME <b>Elizabeth Strong</b></p>			
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)</p>				<p>16. SOCIAL SECURITY NO. <b>213-54-1731</b></p>		<p>17. INFORMANT <b>Mrs Henry Fisher, White Marsh, Md.</b> Address</p>	
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>arteriosclerotic Cardio Vascular Disease</b> DUE TO (b) <b>10 yrs</b> DUE TO (c)</p>							<p>INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b></p>
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</p>							<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/></p>
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>				<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>			
<p>20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b></p>		<p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>		<p>20f. (City or town) (County) (State)</p>	
<p>21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1, 1966</b> to <b>Feb 22, 1966</b>, that (I) (we) last saw the deceased alive on <b>Feb 22, 1966</b>, and that death occurred at <b>11:45 AM</b>, from the causes and on the date stated above.</p>							
<p>22a. SIGNATURE <b>G. M. Gardner</b> M.D.</p>				<p>22b. DATE SIGNED <b>2/23/66</b></p>		<p>ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/></p>	
<p>22c. PHYSICIAN'S NAME (Type) <b>G. M. Gardner</b></p>				<p>22d. ADDRESS <b>Balto 6 Md</b></p>			
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b></p>		<p>23b. DATE THEREOF <b>Feb 26, 1966</b></p>		<p>23c. NAME OF CEMETERY OR CREMATORY <b>Ebenezer Cemetery</b></p>		<p>23d. LOCATION (City, town or county) (State) <b>Chase, Maryland</b></p>	
<p>24. FUNERAL DIRECTOR <b>Walter W. Womack Jr.</b></p>				<p>25a. REC'D BY REGISTRAR <b>FEB 28 1966</b></p>			
<p>ADDRESS <b>Tarring Funeral Home, Aberdeen, Maryland</b></p>				<p>25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b></p>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

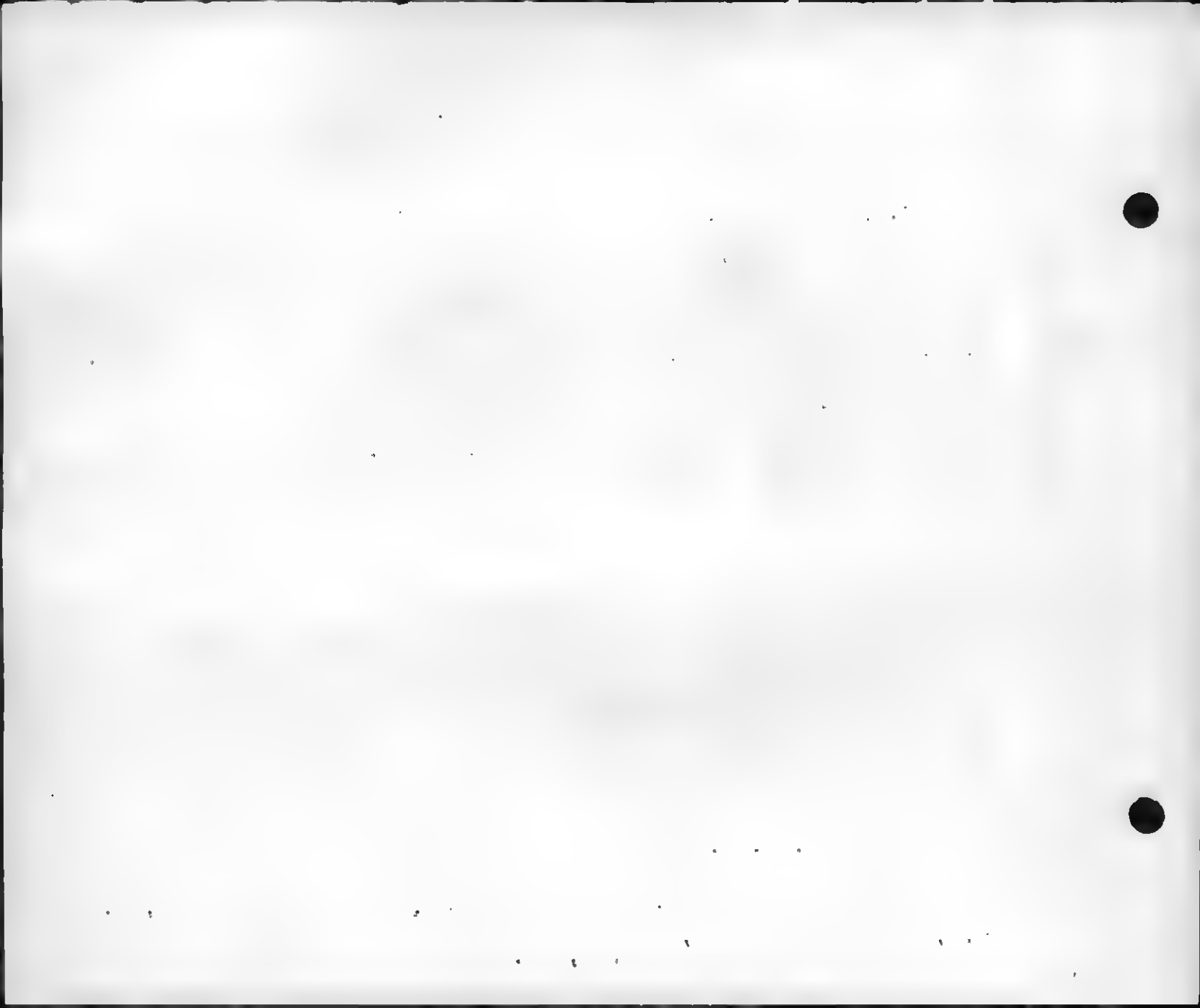
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02037

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
Item 17 Film G 374 2/28/66  
**CERTIFICATE OF DEATH**

01984

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Towson</b> c. LENGTH OF STAY IN IL <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>St. Joseph's Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>379 Evesham Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Marvin</b> Middle <b>Edward</b> Last <b>Ricks</b>		4. DATE OF DEATH Month <b>February</b> Day <b>13</b> Year <b>1966</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 31, 1905</b>
9. AGE (in years last birthday) <b>60</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Self-employed</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>House Painter</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William J. Ricks</b>		14. MOTHER'S MAIDEN NAME <b>Cook</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-07-1557</b>	
17. INFORMANT <b>Mrs. Sarah J. Ricks</b>		Address <b>(Same)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF LUNG</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>none</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>12:00</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Oct 18<sup>th</sup></b> , 19 <b>65</b> to <b>Feb 13</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>January 15, 1966</b> and that death occurred at <b>2:15</b> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <b>A.S. Chalfant</b>		22b. DATE SIGNED <b>Feb 15<sup>th</sup> 66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. A. S. Chalfant</b>		22d. ADDRESS <b>6210 York Road</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/16/1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Prospect Hill Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Towson, Balto. Co., Md.</b>	
24. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co.</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
ADDRESS <b>4905 York Road Balto. 12, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
DATE <b>FEB 16 1966</b>			

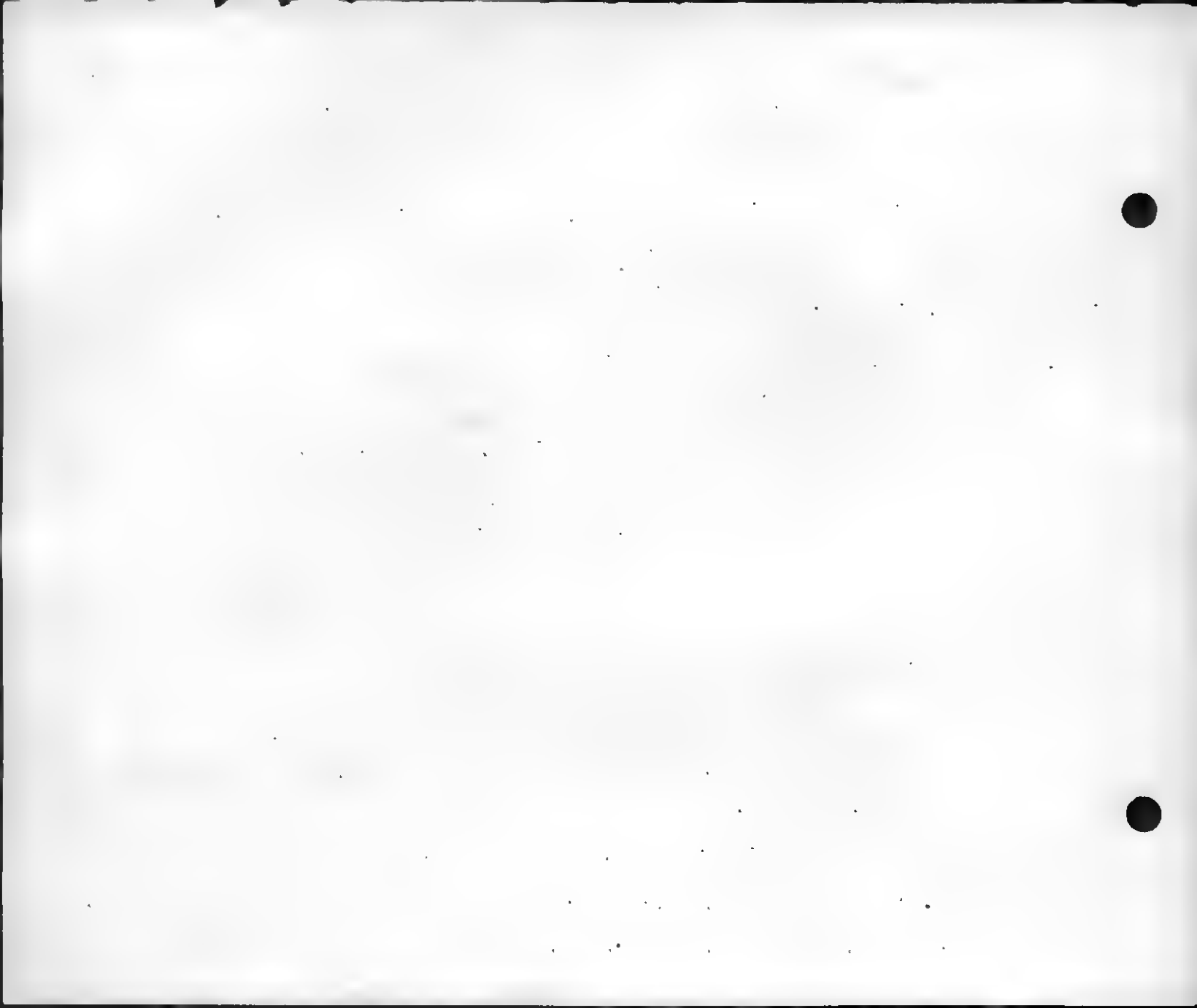


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

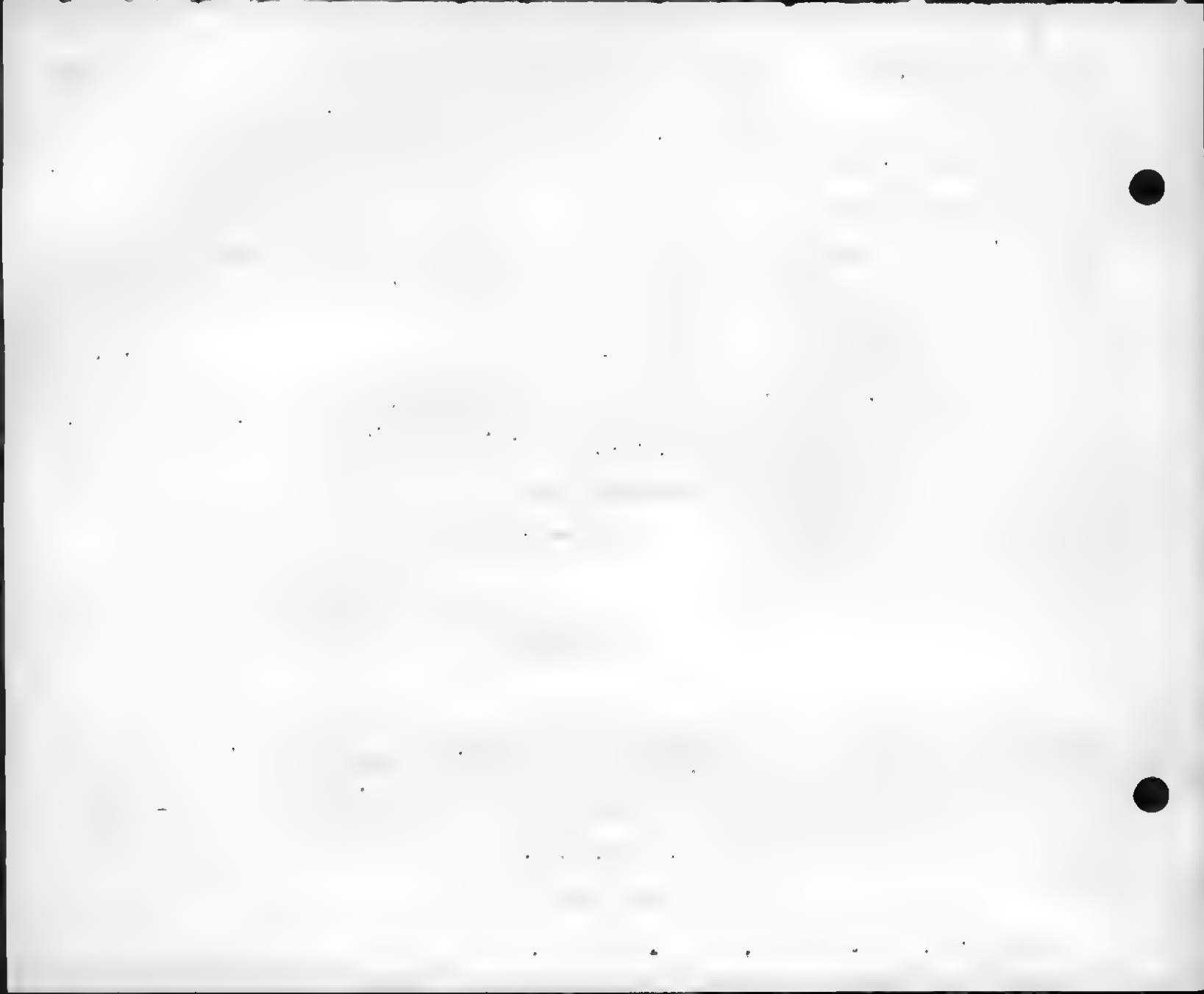
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i></i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>GREATER BALTIMORE MEDICAL CENTER</i>						d. STREET ADDRESS <i>4606 Harford Rd.</i>					
3. NAME OF DECEASED (Type or print) <i>JOHN WILLIAM ROBEL</i>						4. DATE OF DEATH Month <i>FEBRUARY</i> Day <i>9</i> Year <i>1966</i>					
5. SEX <i>MALE</i>		6. COLOR OR RACE <i>WHITE</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>12/17/01</i>		9. AGE (In years last birthday) <i>65</i> yrs.		IF UNDER 1 YEAR Months <i></i> Days <i></i> Hours <i></i> Min. <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Cemetery</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>				12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>William Robel</i>						14. MOTHER'S MARDEN NAME <i>Margaret Mueller</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i></i>		17. INFIRMANT <i>Mrs. Elizabeth M. Robel</i>				Address <i>(SAME)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>BRONCHOGENIC CARCINOMA WITH ENDO-</i> <i>1621</i> DUE TO (b) <i>TRACHEAL BLEEDING.</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i></i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i></i>											
INTERVAL BETWEEN ONSET AND DEATH <i></i>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m. <i></i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>2/9</i> , 19 <i>66</i> , to <i>2/9</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>2/9</i> , 19 <i>66</i> , and that death occurred at <i>1:30</i> PM, from the causes and on the date stated above.											
22a. SIGNATURE <i>Oscar Ferdinandini</i>						22b. DATE SIGNED <i></i>					
22c. PHYSICIAN'S NAME (Type) <i>OSCAR FERNANDINI</i>						22d. ADDRESS <i>Greater Balto. Med. Center.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE THEREOF <i>2/14/66.</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer Cemetery</i>				23d. LOCATION (City, town or county) (State) <i>Baltimore, Md.</i>	
24. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc. Balto. Md. 21214</i>						25a. REC'D BY REGISTRAR <i>FEB 11 1966</i>		25b. REGISTRAR'S SIGNATURE <i>John Charles Judge</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove pages 1 and 2 and return them to the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>1mth 15dys</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Arbutus</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>						d. STREET ADDRESS <b>1837 Clark Boulevard</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Virgil</b>			First <b>Pope</b>			Middle <b>Roberts</b>			Last		
4. DATE OF DEATH <b>February 18 19 66</b>			Month <b>February</b>			Day <b>18</b>			Year <b>19 66</b>		
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7/7/85</b> <b>JULY 7 1985</b>		9. AGE (In years last birthday) <b>80</b> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unemployed</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Oyster Industry</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>Isaac W. ROBERTS</b>						14. MOTHER'S MAIDEN NAME <b>Julia A. ROBERTS</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>218-34-2942</b>		17. INFORMANT <b>MRS. LOTTIE W. ROBERTS</b>		Address <b>5611 WASHINGTON BLVD</b> <b>Records: SPRING GROVE STATE HOSPITAL</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> <b>4200</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> (c) <b>Branchopneumonia</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Branchopneumonia</b>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <del>no</del> (this hospital) attended the deceased from <b>Dec. 29 19 65</b> , to <b>Feb. 18 19 66</b> , that <del>we</del> (we) last saw the deceased alive on <b>Feb. 18 19 66</b> , and that death occurred at <b>6:05 P.</b> M, from the causes and on the date stated above.											
22a. SIGNATURE <b>Stella Wachslar</b>						a. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2-18-66</b>			
22c. PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>						22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL</b> <b>Baltimore, Maryland 21228</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>2/21/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GRACE EPISCOPAL CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>ELKRIDGE MARYLAND</b>					
24. FUNERAL DIRECTOR <b>HUBBARD FUNERAL HOME, 4107 WILKENS AVE. 21229</b>						25a. REC'D BY REGISTRAR <b>FEB 23 1966</b>		25b. REGISTRAR'S SIGNATURE <b>elas Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

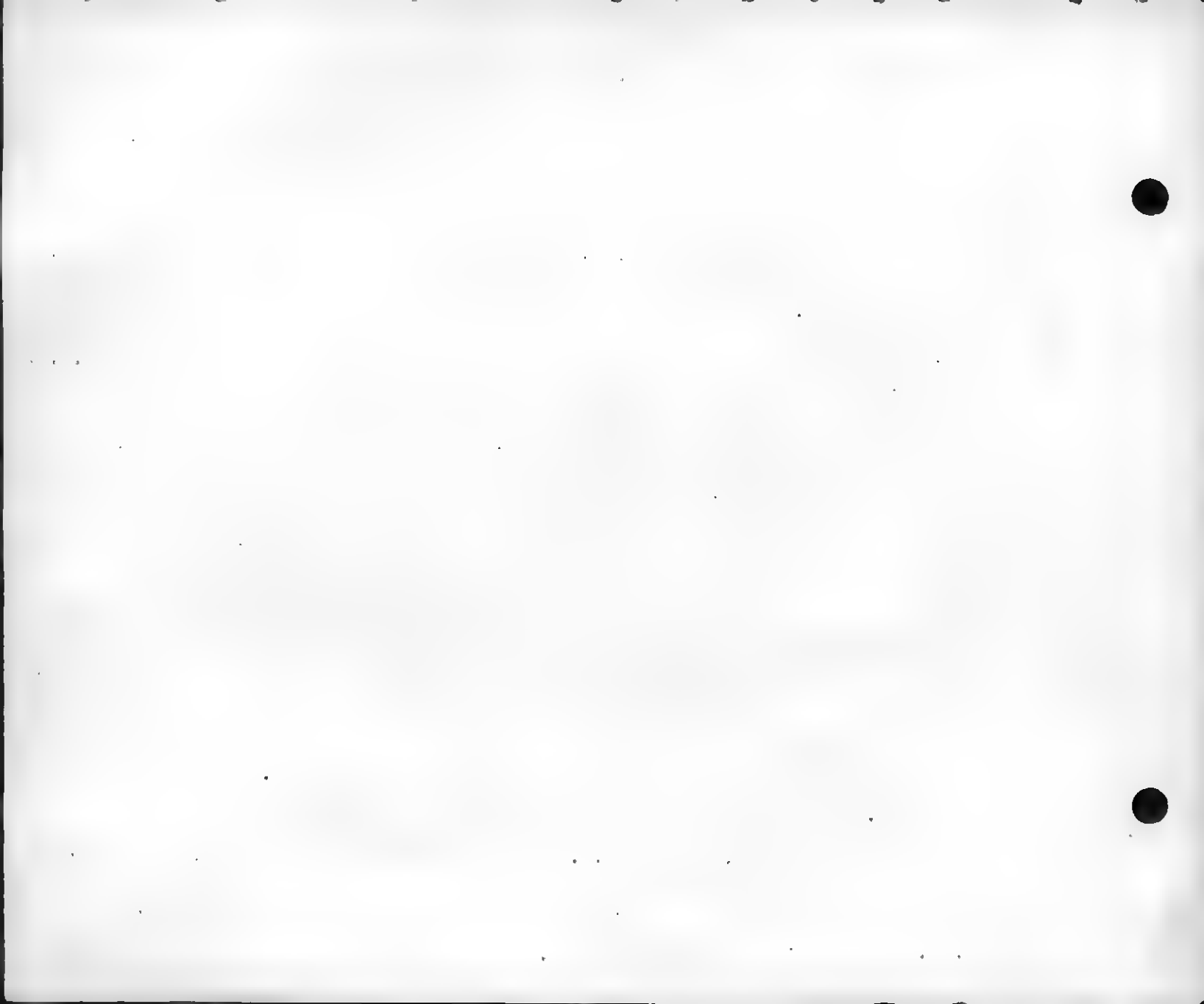
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
02040 CERTIFICATE OF DEATH 01987

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>				c. LENGTH OF STAY IN 1b <b>14 yrs.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Rosewood State Hospital</b>				d. STREET ADDRESS <b>Route 1</b>			
3. NAME OF DECEASED (Type or print) First <b>Patricia</b> Middle <b>Louise</b> Last <b>ROBEY</b>				4. DATE OF DEATH Month <b>2</b> Day <b>22</b> Year <b>19 66</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-27-49</b>	
9. AGE (In years last birthday) <b>16 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dependent</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Olney, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Earl Millard Robey</b>				14. MOTHER'S MAIDEN NAME <b>Ella Dorothy Burris</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Rosewood Records, Owings Mills, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Branchiopneumonia, blet.</b> <b>491X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Emphysema, diffuse and</b> (c) <b>bronchiectasis, blet and</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pulmonary tuberculosis, coronary a.</b>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (if (this hospital) attended the deceased from <b>6/27</b> , 19 <b>66</b> to <b>2/22</b> , 19 <b>66</b> , that (he) last saw the deceased alive on <b>2/22</b> , 19 <b>66</b> , and that death occurred at <b>11:30</b> AM, from the causes and on the date stated above.							
22a. SIGNATURE <b>Harry G. Butler</b>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>23 Feb 66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Harry G. Butler, M.D.</b>				22d. ADDRESS <b>Rosewood Lane, Owings Mills, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/28/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rosewood Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Owings Mills, Md.</b>	
24. FUNERAL DIRECTOR <b>J. F. Eline &amp; Sons Reisterstown, Md.</b>				25a. REC'D BY REGISTRAR <b>MAR 2 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



1  
M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reattach in papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01288

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c LENGTH OF STAY IN 1b <b>03-1</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1353 Dartmouth Avenue</b>		d STREET ADDRESS <b>1353 Dartmouth Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>Bessie</b> Middle <b>May</b> Last <b>Rogers</b>		4 DATE OF DEATH Month <b>February</b> Day <b>24</b> Year <b>1966</b>	
5. SEX <b>female</b>	6 COLOR OR RACE <b>caucasian</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>1880</b> <b>Nov. 10, 1880</b>
9 AGE (In years last birthday) <b>85</b> yrs		10 UNDER 1 YEAR Months <b>1</b> Days <b>24</b> Hours <b>15</b> Min <b>00</b>	
10a USUAL OCCUPATION (Give kind of work done during most of waking life, even if retired) <b>housewife</b>		10b KIND OF BUSINESS OR INDUSTRY <b>housewife</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Calvin Bond</b>		14. MOTHER'S MAIDEN NAME <b>Hannah Ely</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16 SOCIAL SECURITY NO. <b>216097065</b>	
17. INFORMANT <b>Mrs. Edna M. Heins</b>		Address <b>1353 Dartmouth Ave.</b>	
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> 4 21 DUE TO (b) <b>Arteriosclerotic C-V Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <b>Rt. hemiplegia (3 1/2 yrs)</b>		INTERVAL BETWEEN ONSET AND DEATH <b>36 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Mesenteric thrombosis</b>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>		20f. (City or town) (County) (State) <input type="checkbox"/>	
21. I certify that (I) ( <del>was</del> <b>not</b> hospital) attended the deceased from <b>Feb 9, 1954</b> to <b>Feb 24, 1966</b> , that (I) ( <del>was</del> <b>not</b> ) last saw the deceased alive on <b>Feb. 23, 1966</b> , and that death occurred at <b>10:30 AM</b> , from causes and on the date stated above.			
22a SIGNATURE <b>H. V. Harbold</b>		22b. DATE SIGNED <b>Feb. 25, 1966</b>	
22c PHYSICIAN'S NAME (Type) <b>Dr. Harold V. Harbold</b>		22d ADDRESS <b>4706 Harford Road, Baltimore, Md.</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/28/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore Md.</b>	
24 FUNERAL DIRECTOR <b>Leonard J. Ruck Funeral Home, Inc.</b>		25a. REC'D BY REGISTRAR <b>Feb 28 1966</b>	
ADDRESS <b>5305 Harford Road</b>		25b. REGISTRAR'S SIGNATURE <b>James H. Judge</b>	



## CERTIFICATE OF DEATH

Reg. Dist. No. 01089

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Middle River</i>				c. LENGTH OF STAY IN lb			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>37 Honeycomb Road</i>				d. STREET ADDRESS <i>37 Honeycomb Road</i>			
3. NAME OF DECEASED (Type or print) First <i>Bertha</i> Middle <i>A.</i> Last <i>Rohrer</i>				4. DATE OF DEATH Month <i>February</i> Day <i>17</i> Year <i>1966</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>September 1, 1901</i>	
9. AGE (In years last birthday) yrs. <i>64</i>		10. IF UNDER 1 YEAR Months Days Hours Min		11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <i>Henry D. Foulds</i>				14. MOTHER'S MAIDEN NAME <i>Catherine Kramer</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>				16. SOCIAL SECURITY NO. <i>220-20-9839</i>		17. INFORMANT <i>Leon C. Rohrer 37 Honeycomb Road</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute pulmonary edema</i>							<i>1 hour</i>
DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) <i>Acute myocardial infarction</i>							<i>"</i>
DUE TO							
(c) <i>Arteriosclerotic heart disease</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <i>Aug. 20, 1965</i> to <i>2/11, 1966</i> , that I last saw the deceased alive on <i>2/11, 1966</i> , and that death occurred at <i>7:35 P.M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>M. A. Castro Jr.</i>				ADDRESS (Street, city or town, state) <i>805 FUSELAGE AVE, BALTIMORE MD.</i>			
PHYSICIAN'S NAME (Type) <i>M. CASTRO, Jr. M.D.</i>				DATE SIGNED <i>2/11/66</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>2/15/66</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Gardens of Faith Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John A. Moran, Inc. 3000 E. Balto. St. Balto.</i>				24a. REC'D BY REGISTRAR <i>FEB 15 1966</i>		24b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 11 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

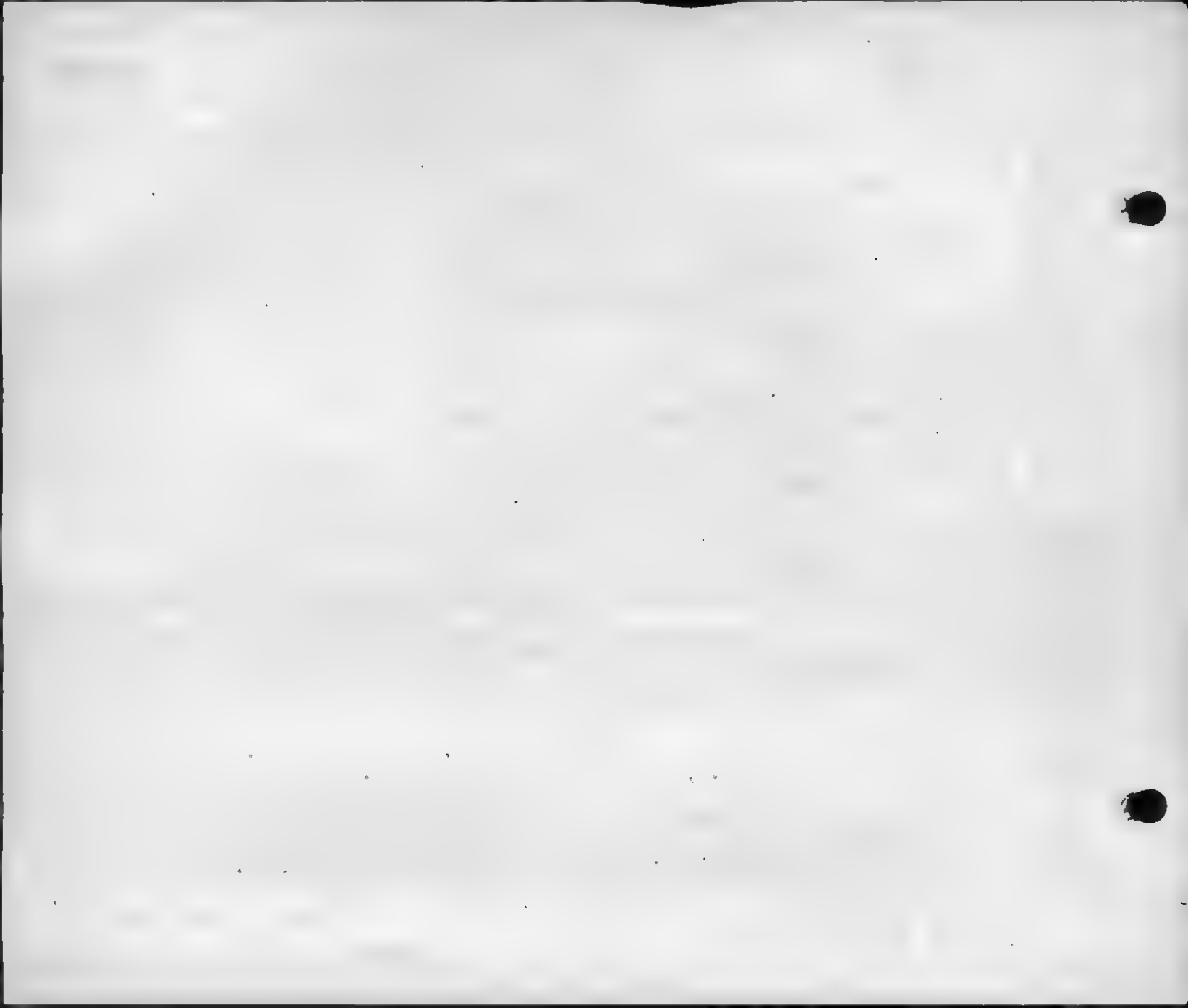
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

32043

01990

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTO.</u>		
c. LENGTH OF STAY IN lb			d. STREET ADDRESS <u>630 Washington Ave #21227</u>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>16 Flushing Ave House in the Pine</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>William Michael Ruhland</u>			4. DATE OF DEATH Month <u>2</u> Day <u>27</u> Year <u>1966</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/7/1872</u>	9. AGE (In years last birthday) <u>93</u> yrs.	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>POLICE MAN</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Police Dept.</u>		
11. BIRTHPLACE (County & State, or foreign country) <u>BALTO. Md</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME <u>Jacob Ruhland</u>			14. MOTHER'S MAIDEN NAME <u>Rose Fahey</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>			16. SOCIAL SECURITY NO.		
17. INFORMANT <u>Ellen R. Dowling</u>			Address <u>126 Malbrook Rd 21229</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion, Acute</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardio-vascular disease</u> DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus, mild</u>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (the hospital) attended the deceased from <u>Feb.</u> , 19 <u>66</u> , to <u>Feb.</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>Feb. 9</u> , 19 <u>66</u> , and that death occurred at <u>3A</u> M, from the causes and on the date stated above.					
22a. SIGNATURE <u>Leo J. Gaver</u> M.D.					
22b. DATE SIGNED <u>2/28/66</u>					
22c. PHYSICIAN'S NAME (Type) <u>Leo J. Gaver</u>					
22d. ADDRESS <u>1 Mallow Hill Ave., Baltimore, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>3/2/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>	
23d. LOCATION (City, town or county) <u>BALTO.</u>		(State) <u>Md</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>E. S. MacNabb</u>			25a. REC'D BY REGISTRAR <u>MAR 1 1966</u>		
ADDRESS <u>301 Frederick Rd Catonsville Md</u>			25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		



AT 8-4664

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02044

01991

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b <b>2 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>GREATER BALTO. MEDICAL CENTER</b>				d. STREET ADDRESS <b>2624 New NORTH PR</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>E.</b> Last <b>Rutkowski</b>		4. DATE OF DEATH Month <b>2</b> Day <b>26</b> Year <b>1966</b>		5. SEX <b>male</b> 6. COLOR OR RACE <b>white</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-2-1900</b> 9. AGE (In years last birthday) <b>65</b> yrs. IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - Shearer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Rheems Mfg. Co.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>POLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A. U.S.A.</b>	
13. FATHER'S NAME <b>Casimir Rutkowski</b>				14. MOTHER'S MAIDEN NAME <b>Frances PROCK</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>215-05-5486</b>		17. INFORMANT <b>Victor Rutkowski</b>		Address <b>Baltimore</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive pulmonary embolism</b> DUE TO (b) <b>acute and chronic</b> DUE TO (c) <b>Peripheral venous thrombosis</b> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.						INTERVAL BETWEEN ONSET AND DEATH <b>3 hrs -</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic cardiovascular disease</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		20g. (City or town) (County) (State)		20h. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Feb. 24</b> , 19 <b>66</b> to <b>Feb. 26</b> , 19 <b>66</b> that (I) <b>we</b> last saw the deceased alive on <b>Feb. 26</b> , 19 <b>66</b> and that death occurred at <b>1:35</b> PM, from the causes and on the date stated above.							
22a. SIGNATURE <b>John E. Adams</b>				22b. DATE SIGNED <b>Feb. 26, 1966</b>		22c. PHYSICIAN'S NAME (Type) <b>John E. Adams M.D.</b>	
22d. ADDRESS <b>Greater Baltimore Medical Centre, Md.</b>				22e. ADDRESS <b>Greater Baltimore Medical Centre, Md.</b>		22f. ADDRESS <b>Greater Baltimore Medical Centre, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Mar-2-1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart of Mary</b>		23d. LOCATION (City, town or county) (State) <b>German Hill Rd. Dundalk, Md.</b>	
24. FUNERAL DIRECTOR <b>JOHN J. DUDA, Dundalk, Md. 21222</b>				25a. REC'D BY REGISTRAR <b>MAR 1 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

100

100

100

100

100

100

100

100

100

100

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sister Our lady of Mount Providence</u>		d. STREET ADDRESS <u>701 Gun Rd.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Sr. Elias Mary Saazedra</u>		4. DATE Month Day Year <u>Feb. 7, 1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cuban</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-20-1881</u>
9. AGE (In years last birthday) <u>84</u> yrs		10. MONTHS <u>8</u>	11. DAYS <u>7</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Religious</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Cuba</u>		12. CITIZEN OF WHAT COUNTRY <u>Cuba</u>	
13. FATHER'S NAME <u>Jose Saazedra</u>		14. MOTHER'S MAIDEN NAME <u>Lazara Hernandez</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Records.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial failure</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>65</u> , to <u>Feb 7</u> , 19 <u>66</u> , that I last saw the deceased alive on <u>Dec</u> , 19 <u>65</u> , and that death occurred at <u>10</u> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Emidio A. Bianco</u> M.D.			
PHYSICIAN'S NAME (Type) <u>Emidio A. Bianco, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Cathedral Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Elliott T. Elison</u>		24a. REC'D BY REGISTRAR <u>Feb 8 1966</u>	
ADDRESS <u>Elliott Funeral Home 129 N. Caroline St.</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



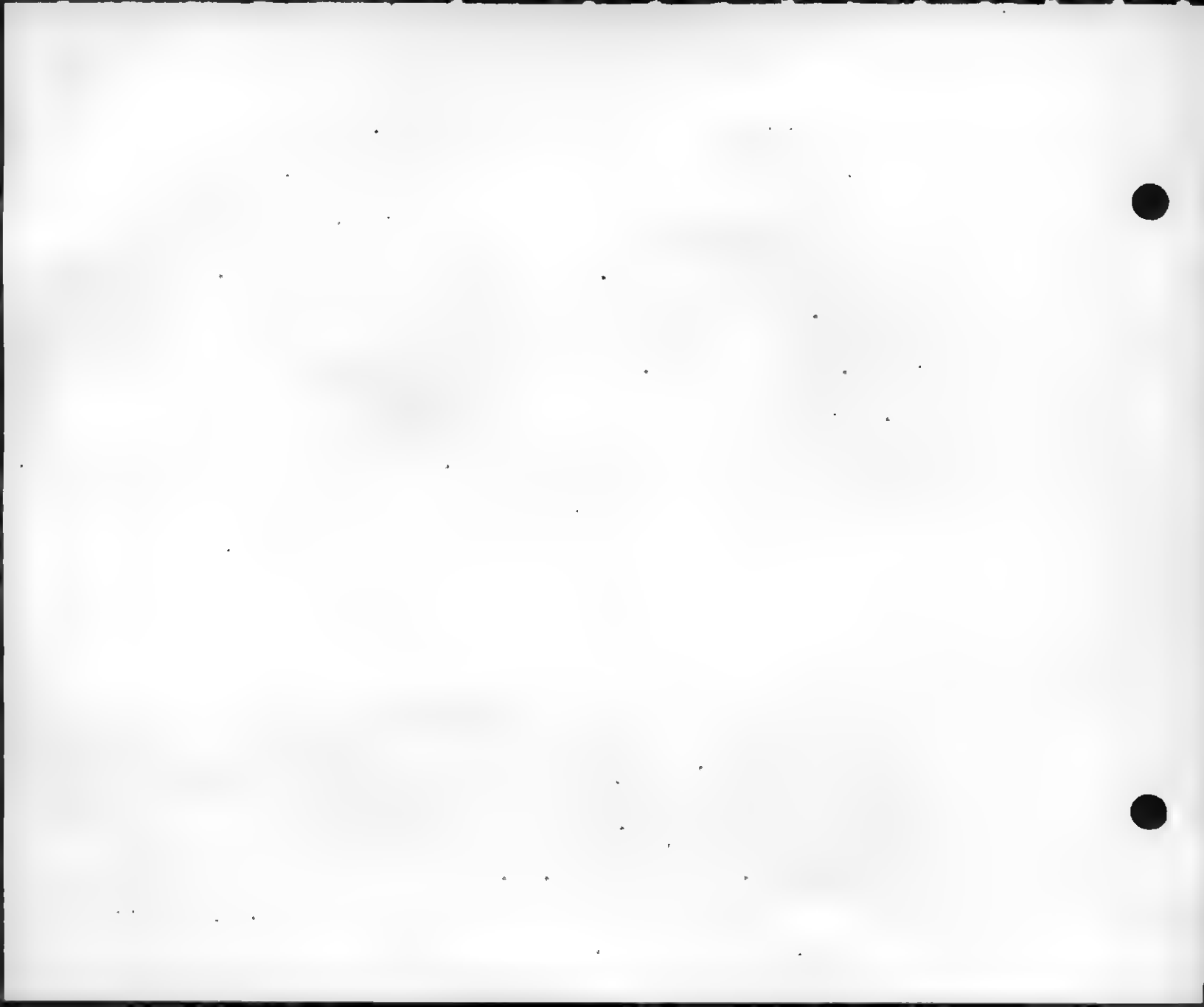
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 72 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore #21</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>L</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Essex</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>18 D Fenway South</u>		d. STREET ADDRESS <u>18 D Fenway South</u>	
3. NAME OF DECEASED (Type or print) First <u>Jesse</u> Middle <u>E.</u> Last <u>Sasser</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>15</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/9/06</u>
9. AGE (in years last birthday) <u>59</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Opr (Pickler)</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Beth. Steel</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>John E. Sasser</u>	
14. MOTHER'S MAIDEN NAME <u>Penny Jones</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	
16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>#21 Ralph O. Sasser, son, 914 Arncliffe Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work et work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Theodore C. Patterson</u>		22. DATE SIGNED	
EXAMINER'S NAME (Type) <u>Theodore C. Patterson, M. D.</u>		Address (Street, city, town, or county) <u>105 Main</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/19/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR <u>Schimunek Funeral Home, Inc.</u>		25a. REC'D BY REGISTRAR <u>FEB 21 1966</u>	
ADDRESS <u>3331 Brehms Lane</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01294

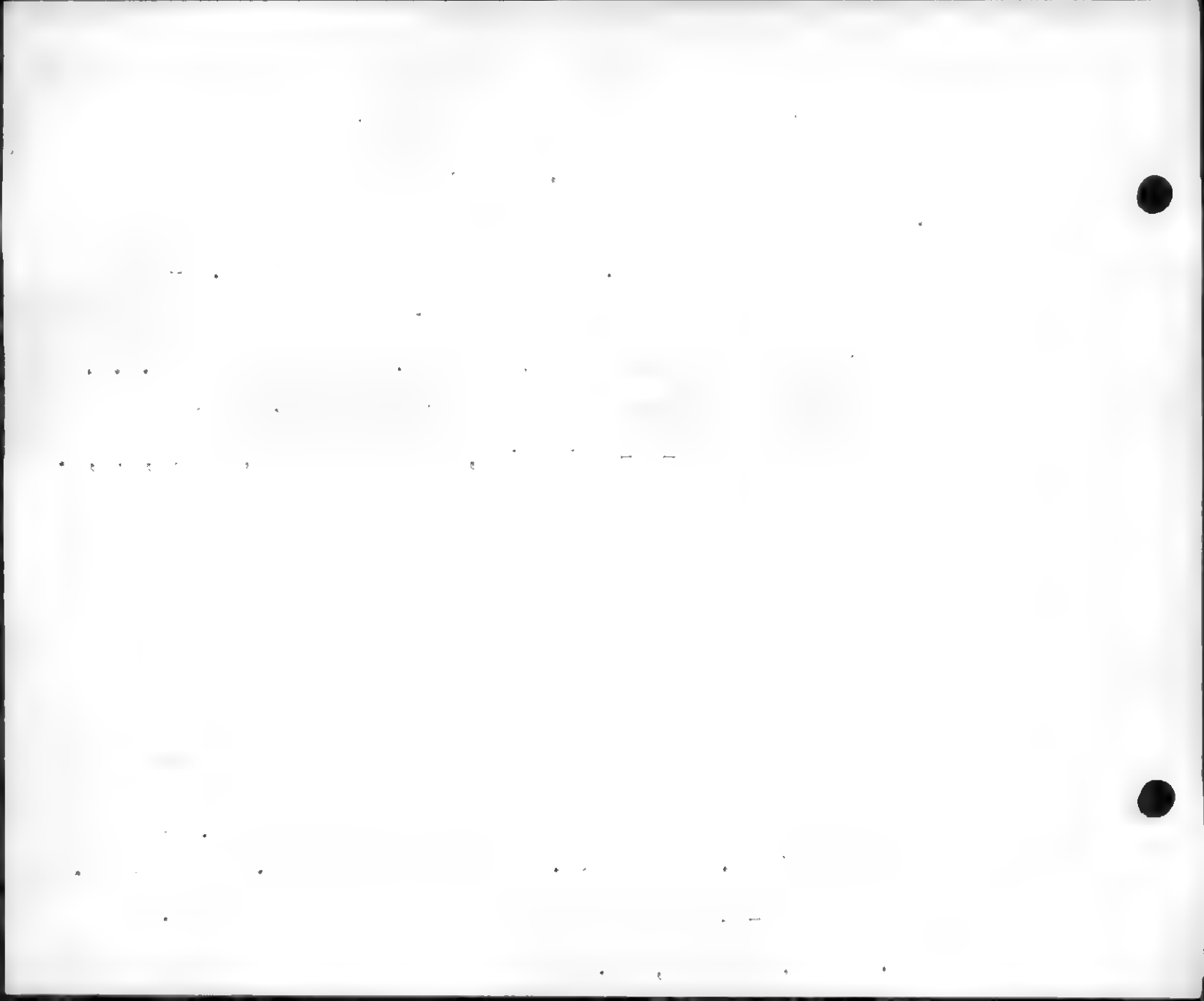
FOR STATE HEALTH DEPT.

02047

1 PLACE OF DEATH a COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Baltimore</b>	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Dundalk</b>		c LENGTH OF STAY IN Td <b>10 yrs.</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Res., 8430 Cove Road</b>		d STREET ADDRESS <b>8430 Cove Road 21222</b>	
3 NAME OF DECEASED (Type or print) <b>AMBROSE T. SCHAEFFER</b>		4 DATE OF DEATH <b>Feb. 1-1966</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>May 17- 1917</b>
9 AGE (in years last birthday) <b>48</b> yrs		10 IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Construction Foreman-Palm Oil Recovery Co., Maryland</b>		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12 CITIZEN OF WHAT COUNTRY?	
13 FATHER'S NAME <b>William Schaeffer</b>		14 MOTHER'S MAIDEN NAME <b>Elizabeth Schaeffer</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no or unknown) <b>No</b>		16 SOCIAL SECURITY NO <b>216-09-2031</b>	
17 INFORMANT <b>Wife, Mary Schaeffer, # 2,a,b,c,d.</b>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO <b>A-5-CV- Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour o.m. pm 19	20d INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Melvin B. Davis</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Melvin B. Davis M.D. 6800 Mornington Rd., Dundalk, Md. 22</b>		ASSISTANT MED. CAL. EXAMINER <input type="checkbox"/> <b>Feb. 3-1966</b> 22 DATE SIGNED	
DEPUTY MED. CAL. EXAMINER <input checked="" type="checkbox"/>			
23a BURIAL, CREMATION, REMOVA (Specify) <b>Burial</b>	23b DATE THEREOF <b>Feb-4-1966</b>	23c NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>	23d LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>
24 FUNERAL DIRECTOR <b>JOHN J. DUDA, Dundalk, Md. 21222</b>		25a RECD BY REGISTRAR <b>DATE FEB 7 1966</b>	25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

02043

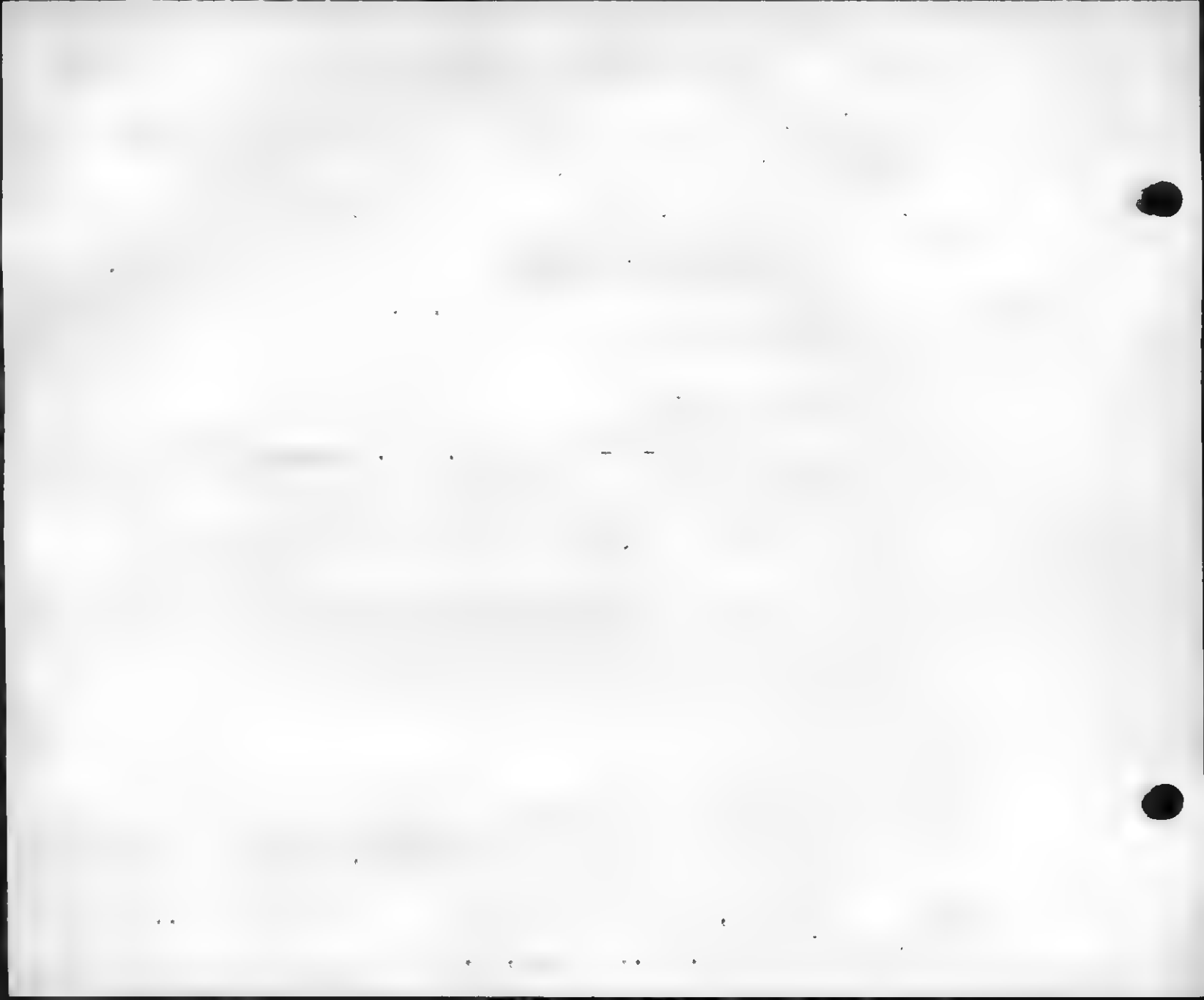
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01995

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk 21222</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk 21222</b>	
c. LENGTH OF STAY IN ID <b>1 year</b>		d. STREET ADDRESS <b>1605 Inverness Avenue</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1605 Inverness Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MAUDE AGNES SCHAUM</b>		4. DATE OF DEATH Month <b>September</b> Day <b>10</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 10, 1886</b>
9. AGE (In years last birthday) <b>79</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Harry Spotswood Frazier</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Scott</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>213-07-3507B</b>	
17. INFORMANT <b>Mrs. R.E. Burkhardt</b>		Address <b>1913 Queensway Dundalk 21222</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> <b>443X</b> OUE TO (b) <b>Hypertensive Cardiovascular</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>Atherosclerosis</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Walter Brooks Bradley</b>		22. DATE SIGNED <b>2/28/66</b>	
EXAMINER'S NAME (Type) <b>Walter Brooks Bradley</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>Dundalk, Maryland</b> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>March 2, 66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Baltimore Co., Maryland</b>
24. FUNERAL DIRECTOR <b>Walter Brooks Bradley, Inc., Dundalk, Md.</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

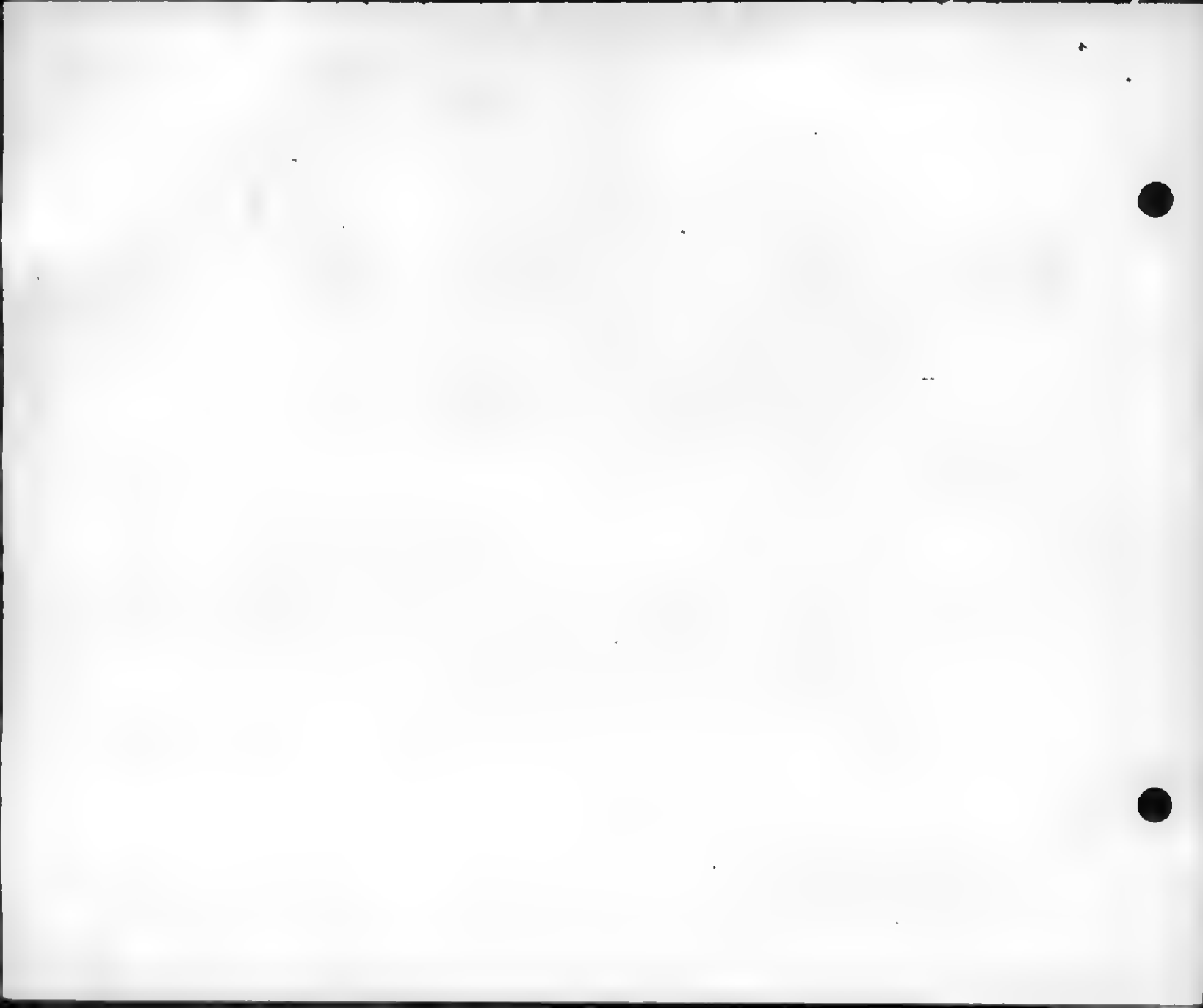
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 48 hours after death.

VR A15ME (5)  
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

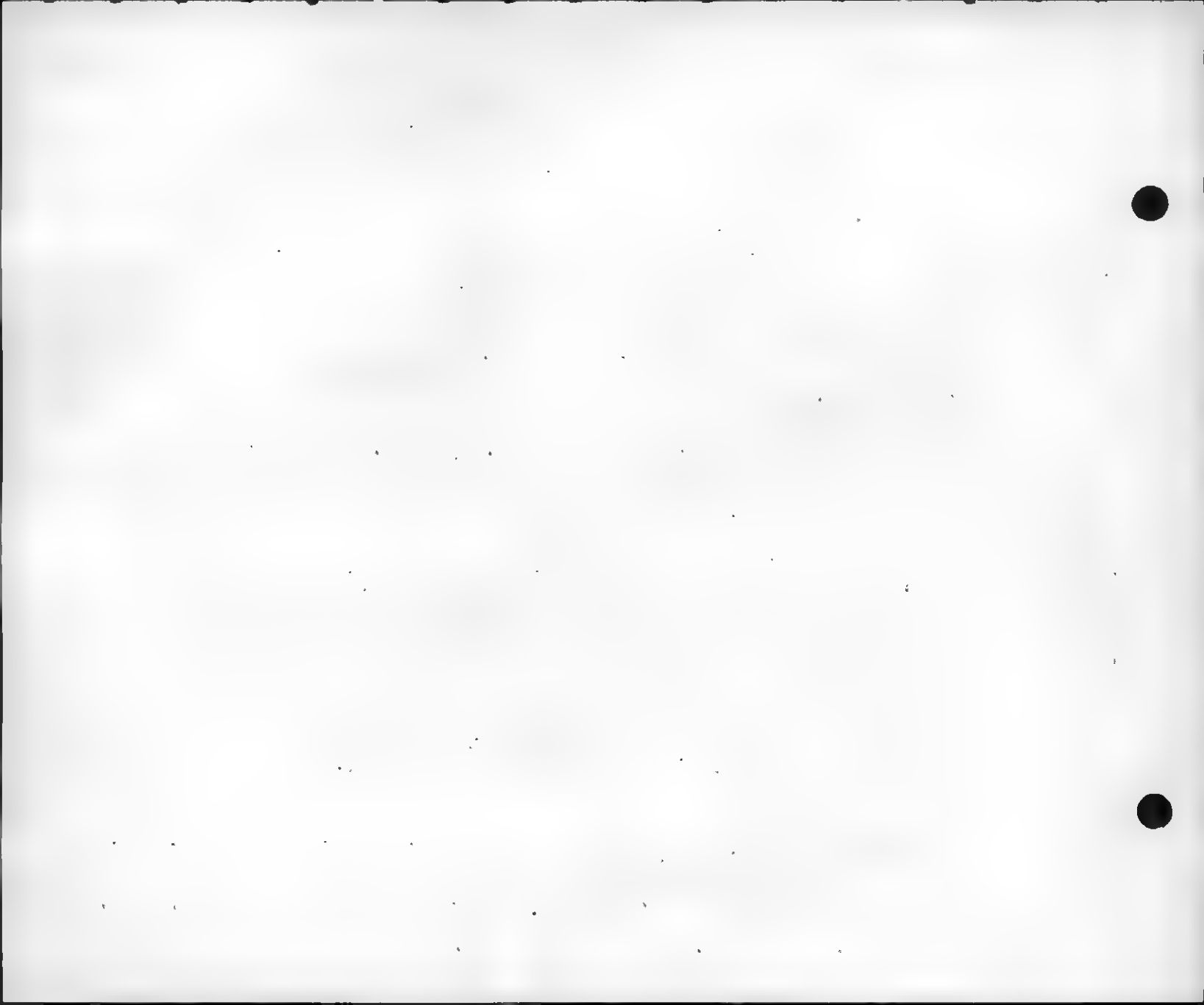
1 PLACE OF DEATH a COUNTY <i>Baltimore</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <i>md.</i> b COUNTY <i>Baltimore</i>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore - 11-45</i>	c LENGTH OF STAY IN 1b <i>5-yr</i>	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore, Md.</i>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>6837 Weddridge Rd</i>		d STREET ADDRESS <i>6837 Weddridge Rd</i>	e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) <i>HYMAN</i>		4 DATE OF DEATH Month <i>Feb</i> Day <i>2</i> Year <i>1966</i>	
5 SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <i>5-20-1918</i>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Stenographer</i>		10b KIND OF BUSINESS OR INDUSTRY <i>Real Estate</i>	9 AGE (In years last birthday) <i>47</i> yrs
11 BIRTHPLACE (State or foreign country) <i>Baltimore, Md</i>		12 CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13 FATHER'S NAME <i>Louis Schneider</i>		4 MOTHER'S MAIDEN NAME <i>Isidore Rosin</i>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <i>yes</i> (If yes give war or dates of service) <i>Army - 1944-1945</i>		16 SOC. SEC. NO. <i>310-01-564</i>	17 INFORMANT <i>Miriam Schneider (wife)</i>
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>1 hr</i>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Emphysema with chronic</i>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH <i>None</i>	20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>None</i>		
20c TIME OF INJURY Month, Day, Year Hour a.m. <i>None</i> p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <i>None</i>	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>D.D. Caples</i>		22. DATE SIGNED <i>2-2-66</i>	
EXAMINER'S NAME (Type) <i>D.D. CAPLES</i>		Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	23b DATE THEREOF <i>2/4/66</i>	23c NAME OF CEMETERY OR CREMATORY <i>BALTIMORE NATIONAL</i>	23d LOCATION (City or town) (County) (State) <i>BALTIMORE, MARYLAND</i>
24 FUNERAL DIRECTOR <i>SOL LEVINSON &amp; BROS. INC. 6010 REISTERSTOWN RD</i>		25a REC'D BY REGISTRAR <i>FEB 7 1966</i>	25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>																									
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u> c. LENGTH OF STAY IN 1b  d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>St. Joseph Hospital</u>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY _____ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore, 21234</u> d. STREET ADDRESS <u>2517 Ventworth Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>																			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>German</u> Middle <u>August</u> Last <u>Schnoor</u>			<b>4. DATE OF DEATH</b> Month <u>February</u> Day <u>23</u> Year <u>1966</u>			<b>5. SEX</b> <u>male</u>			<b>6. COLOR OR RACE</b> <u>white</u>			<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>													
<b>8. DATE OF BIRTH</b> <u>7/23/1896</u>			<b>9. AGE</b> (In years last birthday) <u>69</u> yrs. <table border="1" style="display: inline-table;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td></td> <td>Hours</td> </tr> <tr> <td></td> <td>Min.</td> </tr> </table>			IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days		Hours		Min.	<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired</u>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Balto. Type Foundry</u>			<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Germany</u>			<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>		
IF UNDER 1 YEAR	IF UNDER 24 HRS.																								
Months	Days																								
	Hours																								
	Min.																								
<b>13. FATHER'S NAME</b> <u>August Schnoor</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>? Petersen</u>																			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u>			<b>16. SOCIAL SECURITY NO.</b> <u>056011963</u>			<b>17. INFORMANT</b> <u>Mrs. Emma C. Schnoor-- Same</u>			<b>Address</b>  																
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction with rupture of the papillary muscle.</u> (b) <u>Pulmonary edema</u> (c) <u>Bronchopneumonia, bilateral.</u> (d) <u>Chronic peptic ulcers (2), large.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____												<b>INTERVAL BETWEEN ONSET AND DEATH</b>  													
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)												<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.)  													
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. _____ p.m. <u>19</u>			<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)  			<b>20f. (City or town)</b> _____ <b>(County)</b> _____ <b>(State)</b> _____																
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Feb. 20</u> , 19 <u>66</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>Feb. 23</u> , 19 <u>66</u> , <b>and that death occurred at</b> <u>10:10 AM</u> , <b>from the causes and on the date stated above.</b>																									
<b>22a. SIGNATURE</b> <u>Govinda Rao</u>						<b>22b. DATE SIGNED</b> <u>February 24, 1966</u>																			
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Govinda Rao, M.D.</u>						<b>22d. ADDRESS</b> <u>7620 York Rd. Baltimore, Md. 21204</u>																			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>			<b>23b. DATE THEREOF</b> <u>2/26/66</u>			<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Moreland Cemetery</u>			<b>23d. LOCATION (City, town or county)</b> _____ <b>(State)</b> _____ <u>Baltimore Co., Md.</u>																
<b>24. FUNERAL DIRECTOR</b> <u>Leonard J. Ruck Inc. 5305 Harford Rd.</u>						<b>25a. REC'D BY REGISTRAR</b> <u>FEB 28 1966</u>			<b>25b. REGISTRAR'S SIGNATURE</b> <u>[Signature]</u>																



1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

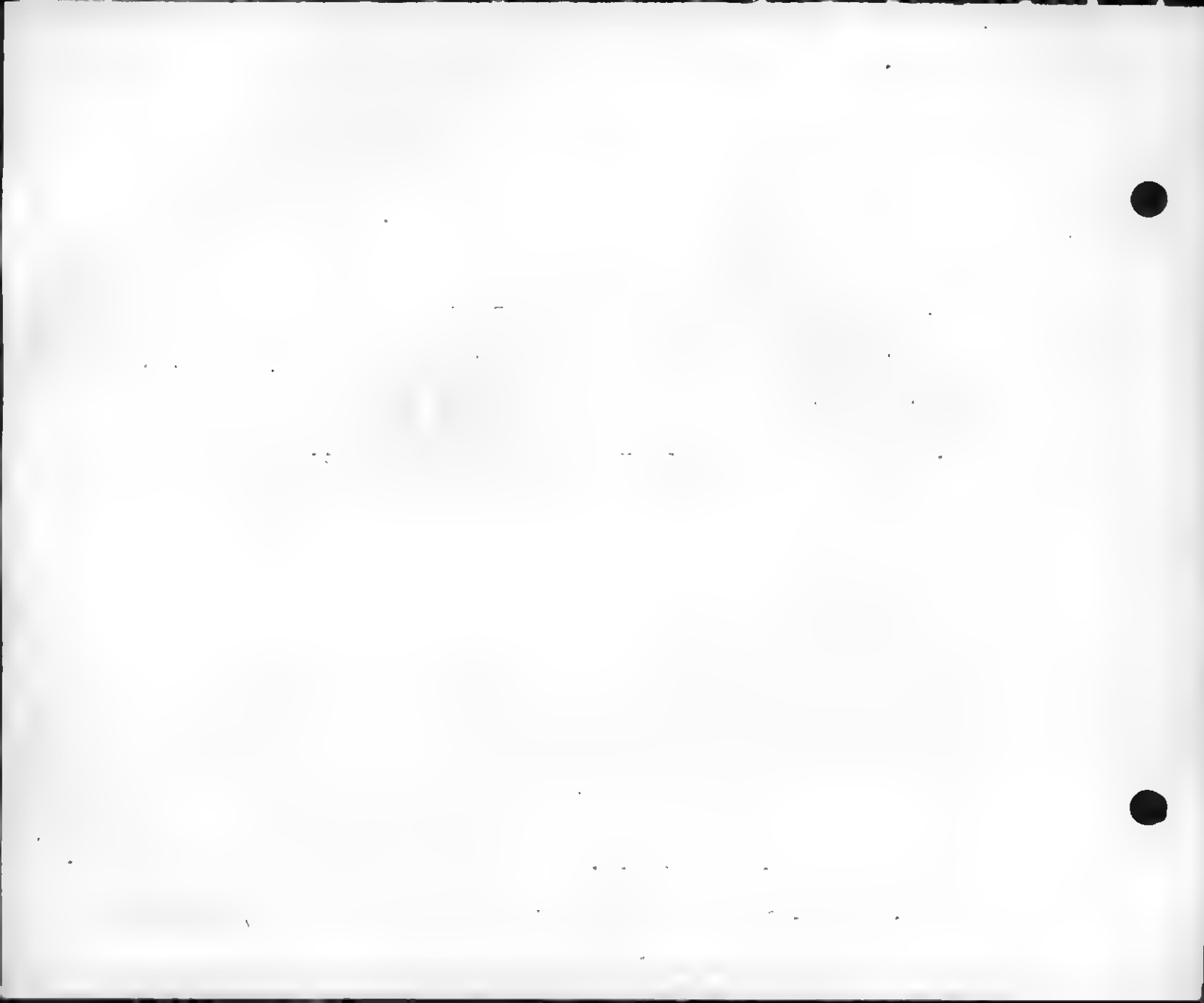
02051

01098

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>✓</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sparrows Point</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Plant Dispensary</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Herman</b> Middle <b>Jackson</b> Last <b>SCOTT</b>		4. DATE OF DEATH Month <b>2</b> Day <b>25</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-19-14</b>
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Burner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Steel Making</b>	9. AGE (In years last birthday) <b>51</b> yrs.
11. BIRTHPLACE (State or foreign country) <b>Nottaway Co. Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Felix Scott</b>		14. MOTHER'S MAIDEN NAME <b>Rosa Rice</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>224-26-9306</b>	
17. INFORMANT <b>Mrs. Geneva Scott</b>		Address <b>1408 Ellwood Ave</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>_____</b> DUE TO (c) <b>_____</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>N</b>			INTERVAL BETWEEN ONSET AND DEATH <b>_____</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>E</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Melvin B. Davis, M.D.</b>		22. DATE SIGNED <b>2-25-66</b>	
EXAMINER'S NAME (Type) <b>Melvin B. Davis, M.D.</b>		6800 Mornington Rd Dundalk, Md. #22	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>3 - 1 - 66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Memorial Park Arbutus, Maryland</b>	23d. LOCATION (City, town or county) (State) <b>Arbutus, Maryland</b>
24. FUNERAL DIRECTOR <b>The Morton &amp; Byett F.H.. 1701 Laurens st</b>		25a. REC'D BY REGISTRAR <b>MAR 1 1966</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

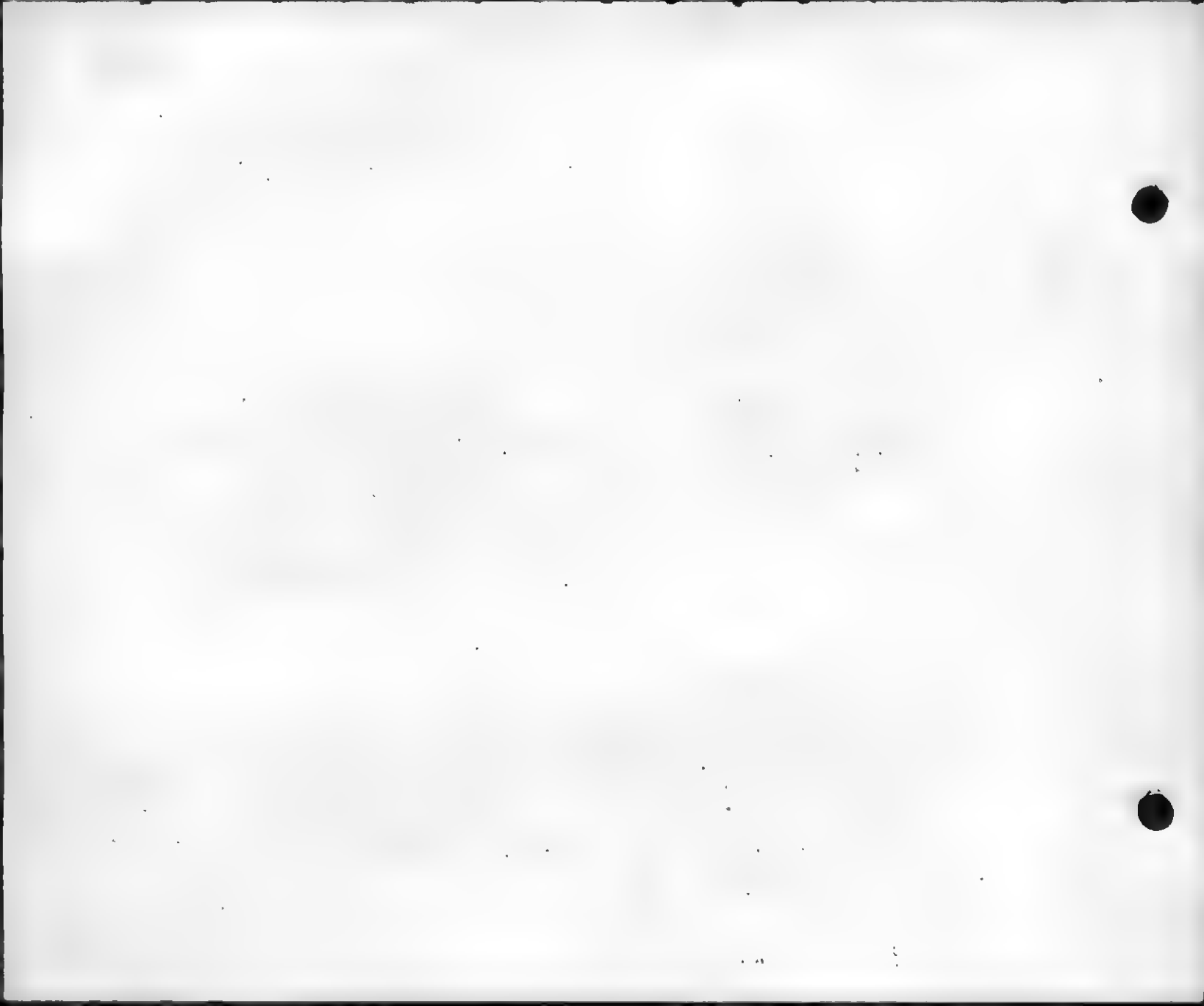


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>TOWSON, BALTIMORE CO. MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>CARROLL</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN ID <b>10 WEEKS</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>UNION BRIDGE</b>				d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>GREATER BALTIMORE MED. CTR</b>						d. STREET ADDRESS <b>BROADWAY EX</b>					
3. NAME OF DECEASED (Type or print) First Middle Last <b>JAMES HARDIN SCOTT</b>						4. DATE OF DEATH Month Day Year <b>2 23 1966</b>					
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-5-92</b>		9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SECRET SERVICE - EXPORT - IMPORT</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <b>MOBERLY, MISSOURI</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>FRANK SCOTT</b>						14. MOTHER'S MAIDEN NAME <b>ORA HARDIN</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>				16. SOCIAL SECURITY NO. <b>WORLDWARI 569-12-3079</b>		17. INFORMANT <b>ELEANORE Q. SCOTT</b>		Address <b>UNION BRIDGE MD</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Artery Rupture, Rt.</b> <b>144X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>Post. irradiation through</b> DUE TO (c) <b>Carcinoma of Oral Cavity</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to <b>FEB 23, 1966</b> , that (I) (we) last saw the deceased alive on <b>FEB 23, 1966</b> , and that death occurred at <b>12:45 M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Manuel V. Gatchalian</b>						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>FEB 23, 1966</b>			
22c. PHYSICIAN'S NAME (Type) <b>MANUEL V. GATCHALIAN</b>						22d. ADDRESS <b>GREATER BALTIMORE MED. CTR</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				23b. DATE THEREOF <b>2-28-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NAT. CEM.</b>		23d. LOCATION (City, town or county) (State) <b>KIRKLINIA</b>			
24. FUNERAL DIRECTOR <b>D. D. Hutzler</b>				ADDRESS <b>UNION BRIDGE MD</b>		25a. REC'D BY REGISTRAR <b>FEB 28 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

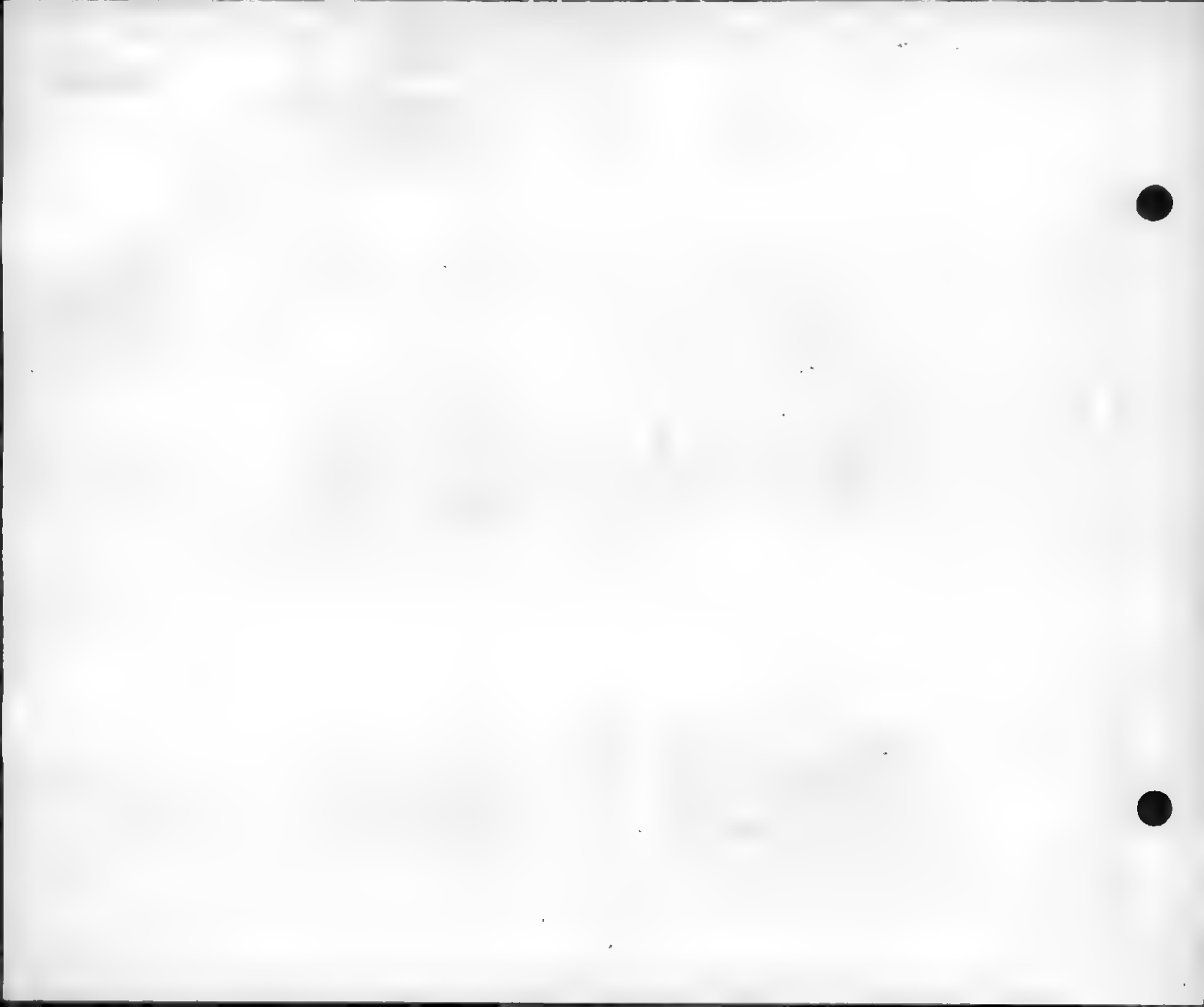
02053

02000

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>BALTO.</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ESSEX</b>		c. LENGTH OF STAY IN 1b <b>ESSEX</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>314 MACE AVE</b>		d STREET ADDRESS <b>314 MACE AVE.</b>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>HARRY O SELF</b>		4. DATE OF DEATH Month Day Year <b>FEB 17 1966</b>	
5 SEX <b>MALE</b>	6 COLOR OR RACE <b>WHITE</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>MAR 3, 1897</b>
9 AGE (In years last birthday) yrs. <b>68</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SELF EMPLOYED</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>GEORGE SELF</b>		14. MOTHER'S MAIDEN NAME <b>- HOOKER</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO <b>213-20-3272</b>	
17. INFORMANT <b>WIFE (SAME AS ABOVE)</b>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>METASTATIC CARCINOMA OF</b> <b>1533</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>SIGMOID COLON</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>13 MO.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>12/17, 1964</b> , to <b>2/17, 1966</b> , that (I) (we) last saw the deceased alive on <b>2/15/66</b> 19__, and that death occurred at <b>1030 PM</b> , from causes and on the date stated above.			
22a SIGNATURE <b>Joseph Miceli</b>		22b DATE SIGNED <b>2/18/66</b>	
22c PHYSICIAN'S NAME (Type) <b>JOSEPH MICELI, MD.</b>		22d ADDRESS <b>108 S. Taylor Ave Essex Md 21221</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>2/21/66</b>	23c NAME OF CEMETERY OR CREMATORY <b>GARDENS OF FAITH</b>	23d. LOCATION (City or Town) (County) (State) <b>BALTO. MD.</b>
24. FUNERAL DIRECTOR <b>CONNELLY SONS 300 MACE AVE, MD.</b>		25a REC'D BY REGISTRAR <b>FEB 21 1966</b>	
25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

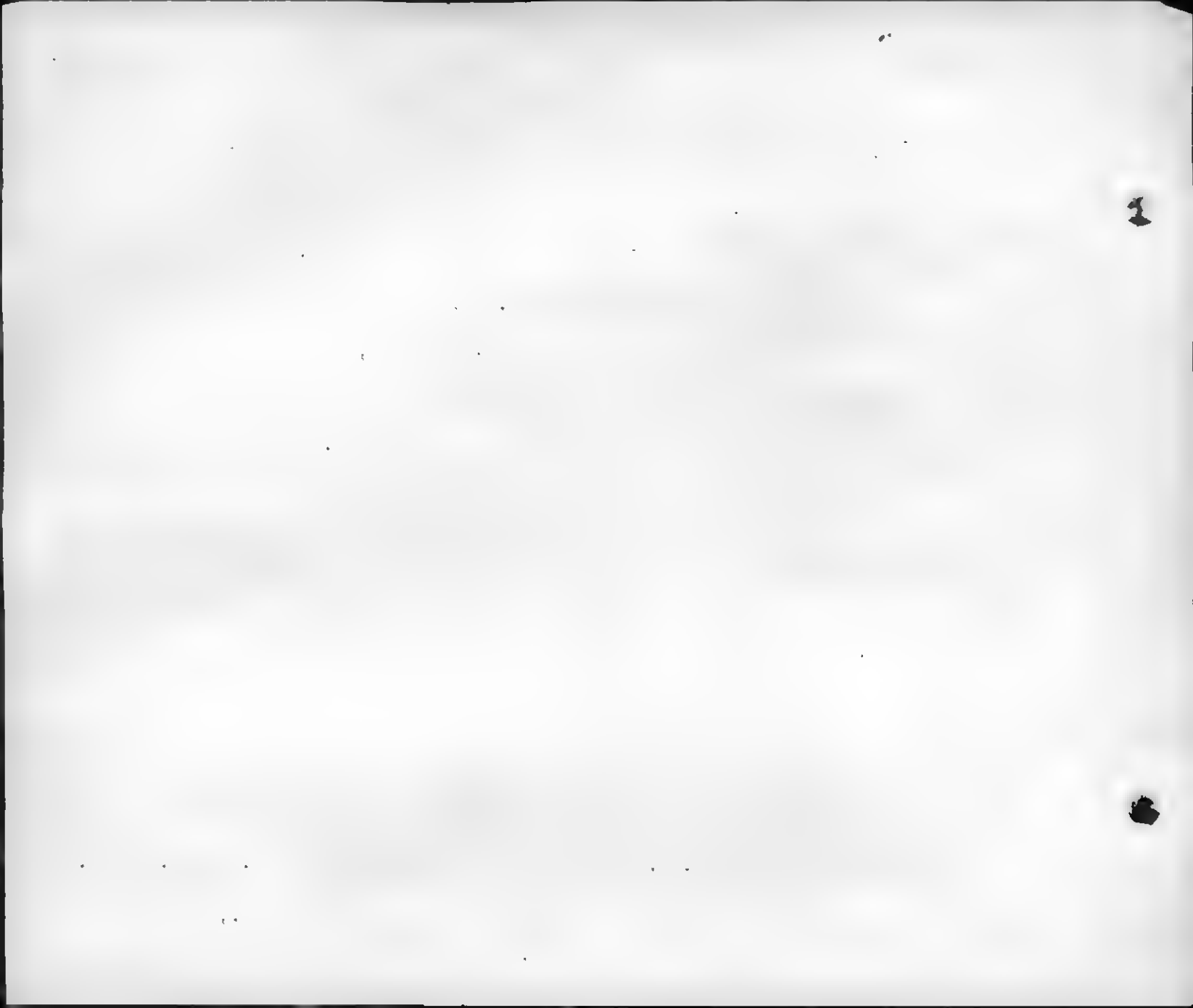
02054

02001

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex (21)</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex (21)</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>827 Back River Neck Road</b>				d. STREET ADDRESS <b>827 Back River Neck Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>MARY JANE SEVIER</b>				4. DATE OF DEATH Month Day Year <b>February 2 19 66</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 15, 1909</b>	9. AGE (In years last birthday) <b>56</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Herbert Michael</b>				14. MOTHER'S MAIDEN NAME <b>Caroline McGlinchy</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>219 22 7998</b>		17. INFORMANT <b>Walter O. Sevier, Jr.</b>		Address <b>Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary thrombosis.</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Myocardiosis</b> DUE TO (c) <b>Diabetes Mellitus</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b> <b>10 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Ca of lung</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Baltimore</b>	(County) <b>Baltimore</b>	(State) <b>Md.</b>		
21. I certify that (I) (this hospital) attended the deceased from <b>1964</b> to <b>Jan 20 19 66</b> that (I) (we) last saw the deceased alive on <b>Jan 20 19 66</b> and that death occurred at <b>6 P</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Leopoldo Gruss M. D.</b>		M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Leopoldo Gruss M. D.</b>		22d. ADDRESS <b>405 Stemmers Run Rd. Balto. 21 Md.</b>					
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>2/5/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore Co., Maryland</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>James Bruzdinski</b>			25a. REC'D BY REGISTRAR <b>FEB 7 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02055

## CERTIFICATE OF DEATH

03481

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u> c. LENGTH OF STAY IN 1b <u>10</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Bent Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Charles</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Newburg</u> d. STREET ADDRESS <u>PI Box # 20664</u>	
3. NAME OF DECEASED (Type or print) <u>JANIE</u> First Middle Last		4. DATE OF DEATH <u>Shanks</u> 2 25 1966 Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>NEG.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>approx 1891</u>
9. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>mail</u>		10a. KIND OF BUSINESS OR INDUSTRY <u>house work</u>	10b. BIRTHPLACE (County & State, or foreign country) <u>Charles County, Md.</u>
11. FATHER'S NAME <u>UNKNOWN</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		14. MOTHER'S MAIDEN NAME <u>Jouellen Wells</u>	
15. SOCIAL SECURITY NO. <u>NONE</u>		16. INFORMANT <u>Robert Brown, Newburg, Md.</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4500</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>arteriosclerosis - generalized</u> (c) DUE TO <u>heart</u>		18. INTERVAL BETWEEN ONSET AND DEATH <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		19b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20d. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2-12-66</u> to <u>2-25-66</u> , that (I) (we) last saw the deceased alive on <u>2-18-66</u> , and that death occurred at <u>2:30 PM</u> , from the causes and on the date stated above			
22a. SIGNATURE <u>C. E. McWilliam</u>		22b. DATE SIGNED <u>February 25, 1966</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <u>Reisterstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>3-1-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>SHILOH Methodist Ceme.</u>	23d. LOCATION (City, town or county) (State) <u>Newburg, Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. K. EDELMAN</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>MAR 7 1966</u>	



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

02036

02002

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. C.TY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>FT. HOWARD</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>FT. HOWARD VA HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. C.TY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Sparrows Point</b> d. STREET ADDRESS <b>Rm. #39 - 1005 "K" Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ROBERT</b>		4. DATE OF DEATH <b>2 6 1966</b>		5. SEX <b>Male</b>	
6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-20-1893</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>STEEL</b>		9. AGE (In years, last birthday) <b>72 yrs.</b>	
11. BIRTHPLACE (State or foreign country) <b>GOOCHLAND CO. VA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>WILLIAM SHELTON</b>	
14. MOTHER'S MAIDEN NAME <b>BETTY MINOR</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>218-07-3254 Mrs. Emma Anderson RT3, MINERAL VA</b>		16. SOCIAL SECURITY NO. <b>218-07-3254</b>	
17. INFORMANT <b>Address</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fatty infiltration of liver</b> DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: _____		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>RUSSELL S. FISHER, M.D.</b>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>2-7-66</b>	
EXAMINER'S NAME (Type) <b>RUSSELL S. FISHER, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>Feb. 10, 1966</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Family</b>	
22d. LOCATION (City, town, or country) <b>GOOCHLAND COUNTY VA</b>		22e. REC'D BY REGISTRAR <b>FEB 11 1966</b>		22f. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
23. FUNERAL DIRECTOR <b>C. H. Lacy</b>		ADDRESS <b>Onchid, VA</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02057

## CERTIFICATE OF DEATH

02003

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>338 Homberg Ave.</u>				d. STREET ADDRESS <u>338 Homberg Ave.</u>			
3. NAME OF DECEASED (Type or print) <u>ELIZABETH A SHERLOCK</u>				4. DATE OF DEATH <u>Feb. 1</u> 19 <u>66</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 21, 1878</u>	9. AGE (In years last birthday) <u>87</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>N. Va.</u>		
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Jacob Raber</u>				
14. MOTHER'S MAIDEN NAME <u>Rebecca?</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				
16. SOCIAL SECURITY NO.			17. INFORMANT <u>Ann L. Myers (same as above)</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAL FAILURE</u> <u>4200</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIO-SCLEROTIC HEART</u> DUE TO (c) <u>DISEASE</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 WEEKS</u>  <u>14 YRS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>BRONCHO-PNEUMONIA</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>MAY 3</u> , 19 <u>55</u> to <u>FEB 1</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>JAN 11</u> , 19 <u>66</u> , and that death occurred at <u>2200</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Joseph Miceli</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2/2/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOSEPH MICELI M.D.</u>				22d. ADDRESS <u>108 S. TAYLOR AVE. ESSEX, MD 21221</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>2/3/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Sylvan Heights Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Uniontown Pa.</u>	
24. FUNERAL DIRECTOR <u>Connolly 300 Mace Ave. Balto. 21</u>				25a. REC'D BY REGISTRAR <u>FEB 3</u> 19 <u>66</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

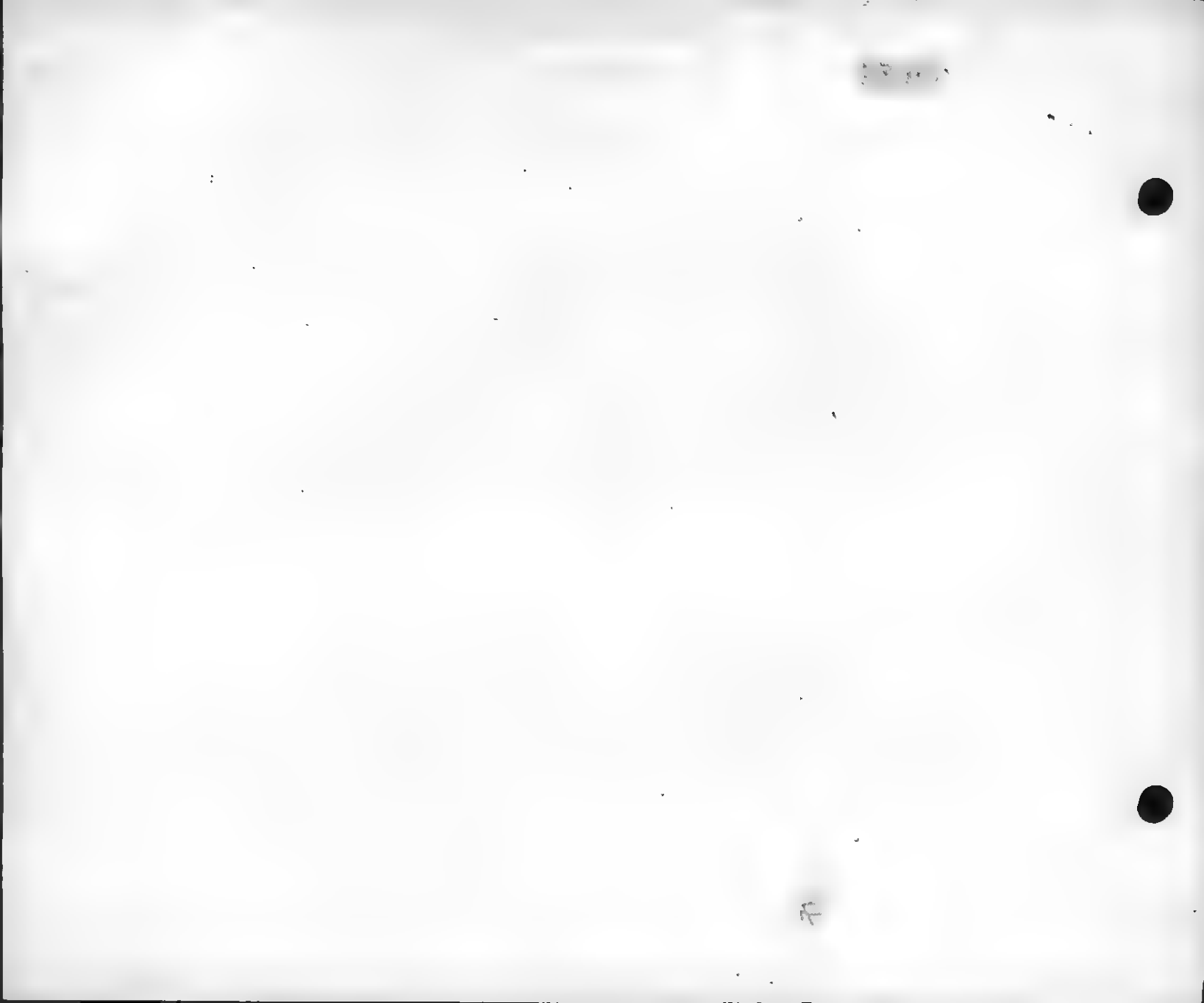
02058

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0004

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a COUNTY <b>BALTO.</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived F institution Residence before admission) a STATE <b>MD</b> b COUNTY <b>BALTO.</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Springville</b>		c LENGTH OF STAY IN MD <b>26 yrs</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Long Park Rd.</b>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>JOSEPH SHIPE</b>		4 DATE OF DEATH <b>FEB 2 1966</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Oct 10 1883</b>
9 AGE (In years last birthday) <b>82</b>		F UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>carpenter</b>		10b KIND OF BUSINESS OR INDUSTRY <b>carpenter</b>	
11 BIRTHPLACE (State or foreign country) <b>Virginia</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>LORENZO SHIPE</b>		14 MOTHER'S MAIDEN NAME <b>MARY KINKER</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>220-01-2567</b>	
17 INFORMANT <b>ANNIE SHIPE (Sister)</b>		Address	
18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>4221</b> <b>contraction of the heart</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>arteriosclerosis</b> DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>arteriosclerosis</b>			
19 WAS A TOLPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) <b>None</b>	
20c TIME OF INJURY Month Day Year Hour am pm <b>7:45 pm</b>		20d INJURY OCCURRED Where <input type="checkbox"/> Not Where <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>D.D. Caples</b>		22. DATE SIGNED <b>2-3-66</b>	
EXAMINER'S NAME (Type) <b>D.D. CAPLES</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b DATE THEREOF <b>FEB 5 1966</b>	
23c NAME OF CEMETERY OR CREMATORY <b>Liberty Mem.</b>		23d LOCATION (City or Town) (County) (State) <b>Carroll Co Md.</b>	
24 FUNERAL DIRECTOR <b>Long Byers</b>		25a REC'D BY REGISTRAR <b>FEB 1 1966</b>	
ADDRESS <b>8728 Liberty Rd, 21133</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

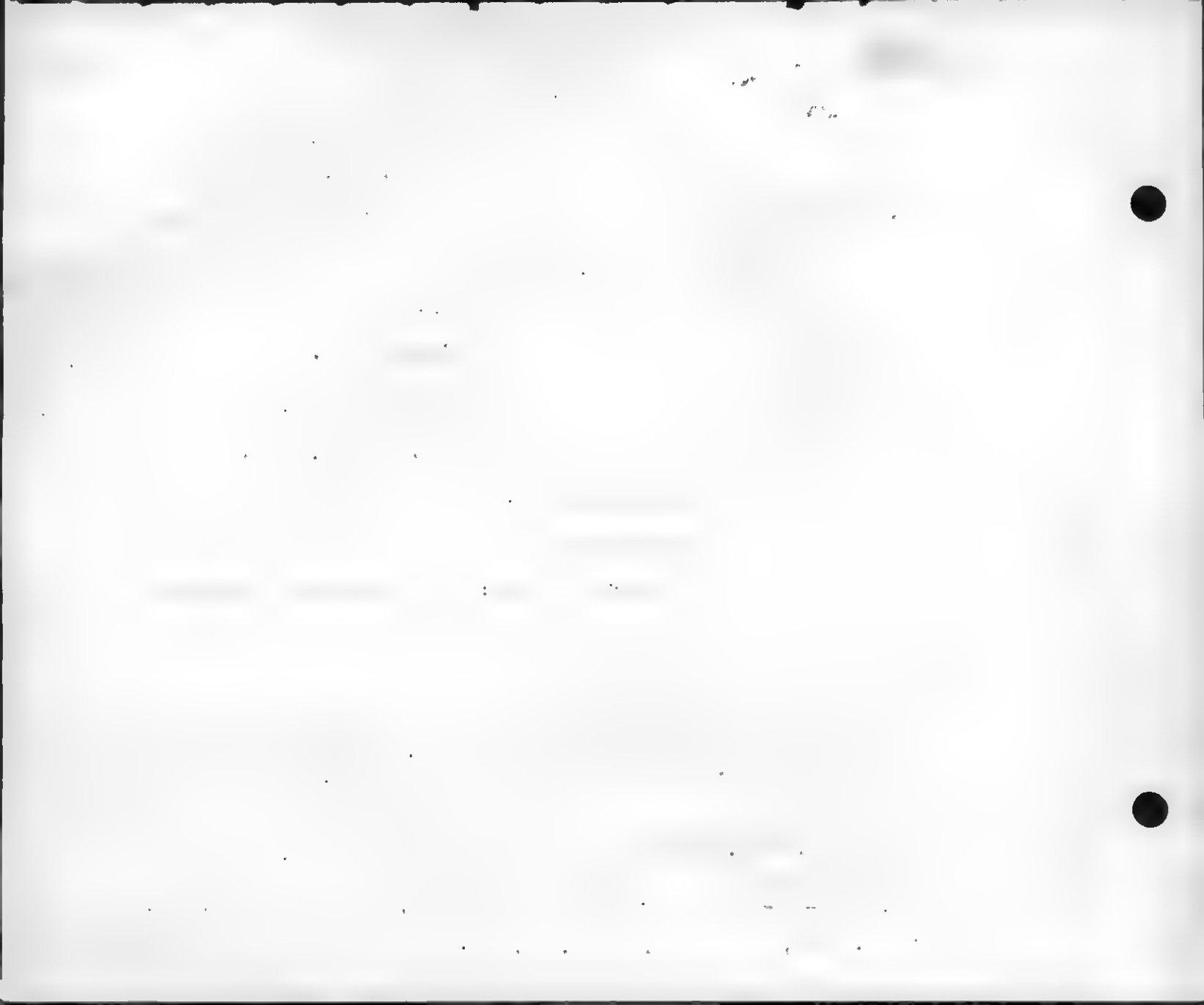


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
02059 CERTIFICATE OF DEATH 02005									
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Towson</b> c. LENGTH OF STAY IN ID <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>St. Joseph Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto., Md.</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>8354 Old Philadelphia Rd. #6</b> d. STREET ADDRESS <b>8354 Old Philadelphia Rd. #6</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Amelia</b>			First <b>L.</b> Middle <b>Shores</b> Last			4. DATE OF DEATH <b>February 22 19 66</b>		Month <b>February</b> Day <b>22</b> Year <b>19 66</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1-8-1924</b>		9. AGE (in years last birthday) <b>42</b> yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph Drasal</b>					14. MOTHER'S MAIDEN NAME <b>Amelia Levecheck</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Alvin P. Shores, Sr.</b>		Address <b>same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory failure</b> <b>170X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hydrothorax</b> DUE TO (c) <b>Carcinoma of breast with widespread metastasis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>February 16, 1966</b> to <b>February 22, 1966</b> , that (I) (we) last saw the deceased alive on <b>Feb. 22, 1966</b> , and that death occurred at <b>4:00 P.M.</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>Nelson S. delaPaz</b>				M.O. ATTENDING PHYS. <input type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>2-22-66</b>			
22c. PHYSICIAN'S NAME (Type) <b>Nelson S. delaPaz</b>				22d. ADDRESS <b>7620 York Road, 21204</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>2-26-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>			
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Ruck Inc.</b>				ADDRESS <b>Balto. Md. 21214</b>		25a. REC'D BY REGISTRAR <b>FEB 24 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

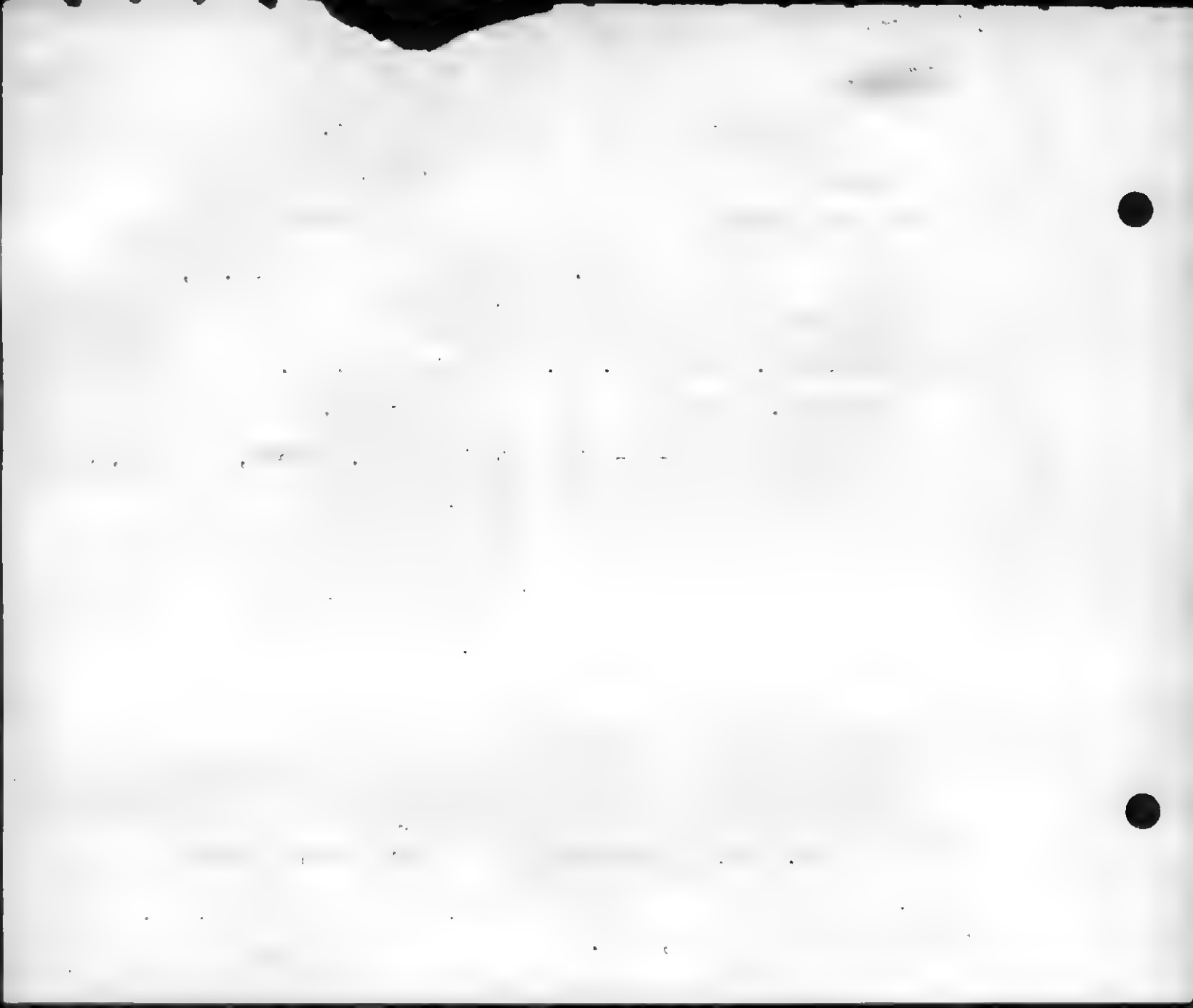
**02060****02006**

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Eastwood</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Eastwood</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>7009 Bank Street</b>				d. STREET ADDRESS <b>7009 Bank Street</b>			
3. NAME OF DECEASED (Type or print) First <b>CORA</b> Middle <b>K.</b> Last <b>SIEBER</b>				4. DATE OF DEATH Month <b>Feb.</b> Day <b>4</b> Year <b>19 66</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/6/1900</b>	9. AGE (in years last birthday) <b>65</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Button Hole Opr. Best Mfg. Co.</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore, Md.</b>		11. BIRTHPLACE (County & State, or foreign country)		
12. CITIZEN OF WHAT COUNTRY?			13. FATHER'S NAME <b>Robert H. Burton</b>				
14. MOTHER'S MAIDEN NAME <b>Anna K. Maul</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				
16. SOCIAL SECURITY NO. <b>215-22-5921</b>			17. INFORMANT Address <b>Christian E. Sieber, husband, above</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cerebrovascular accident</b> 201X DUE TO (b) <b>intracranial pressure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>probably brain tumor</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>severe vomiting</b>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Dec 7</b> , 19 <b>64</b> to <b>Nov 6</b> , 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>Nov 6</b> 19 <b>65</b> , and that death occurred at <b>10:20</b> A.M. from the causes and on the date stated above.							
22a. SIGNATURE <b>Rafael Santayana M.D.</b>							22b. DATE SIGNED <b>Feb. 5 1966</b>
22c. PHYSICIAN'S NAME (Type) <b>Dr. Rafael Santayana</b>							22d. ADDRESS <b>6010 Eastern Avenue</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/7/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR ADDRESS <b>Schimunek Funeral Home, Inc.</b>				25a. REC'D BY REGISTRAR <b>DATE FEB 7 1966</b>			
25b. REGISTRAR'S SIGNATURE <b>3331 Brehms Lane</b>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

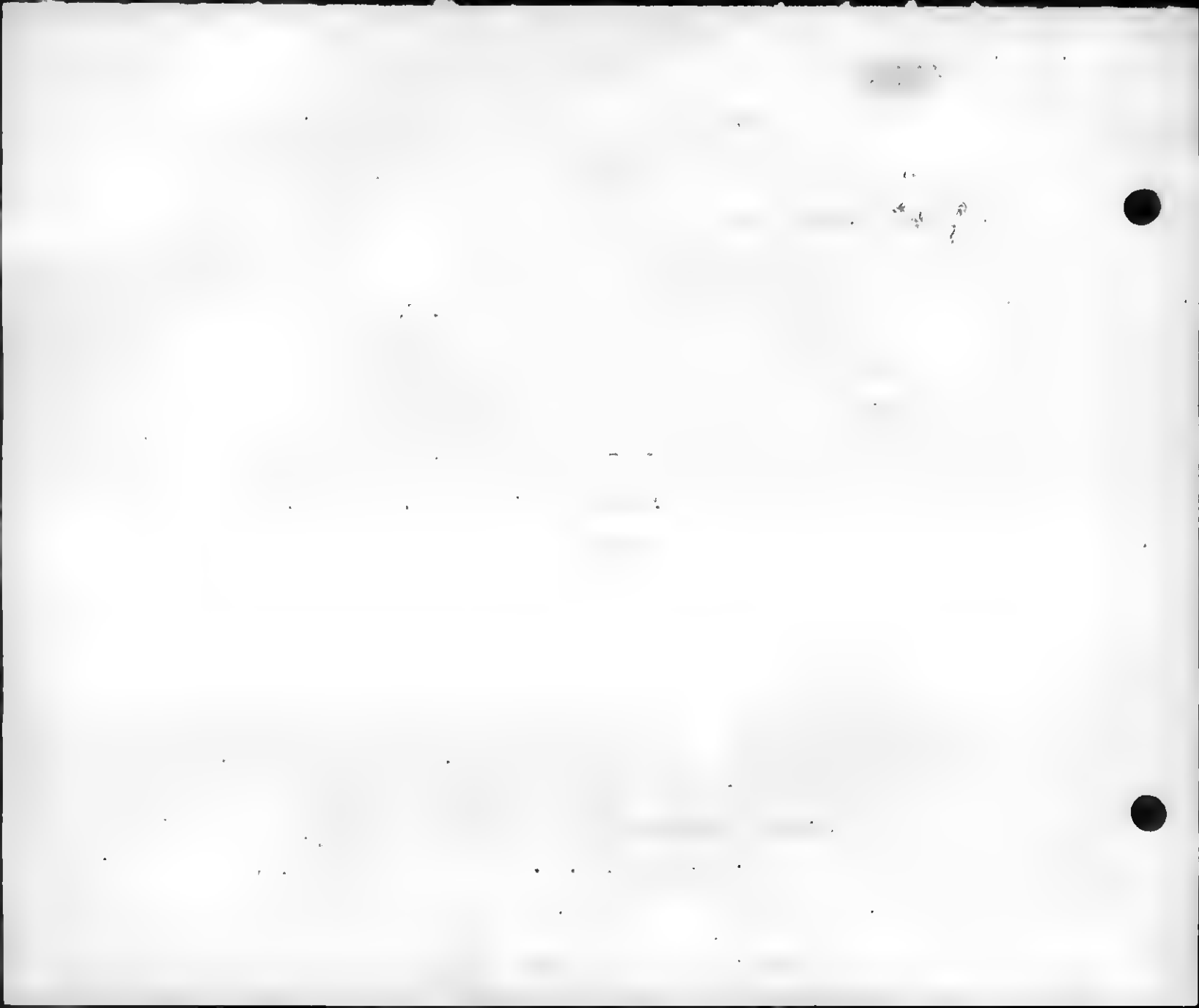
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

02061

02007

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN 1b <b>3mth26dys</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cecilton, Maryland</b> d. STREET ADDRESS <b>none</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Cora</b> Middle <b>Sigman</b> Last <b>Sigman</b>		4. DATE OF DEATH Month <b>February</b> Day <b>6</b> Year <b>1966</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 9, 1886</b>
9. AGE (In years last birthday) <b>79</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>unknown</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>unknown</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>unknown</b>		14. MOTHER'S MATEOEN NAME <b>unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>213-10-6276</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address <b>SPRING GROVE STATE HOSPITAL</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> (c) <b>1200</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>1200</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <del>the</del> (this hospital) attended the deceased from <b>Oct. 10, 1965</b> , to <b>Feb. 6, 1966</b> , that <del>we</del> last saw the deceased alive on <b>Feb. 6</b> 19 <b>66</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Stella Wachslar</b> M.O.		22b. DATE SIGNED <b>2-6-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M.D.</b>		22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</b>	
23a. BURIAL, CREMATION, or REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>2-9-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Heavly Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Heavly Md</b>
24. FUNERAL DIRECTOR <b>H. Hamilton Harrison, Jr. Michael</b>		25a. REC'D BY REGISTRAR <b>FEB 10 1966</b>	
ADDRESS <b>me</b>		25b. REGISTRAR'S SIGNATURE <b>J. J. J. J.</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02062

02008

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Longgreen</b>		c. LENGTH OF STAY in 1b <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Longgreen</b>		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>John</b>		First		Middle		Last <b>Silgot</b>		4. DATE OF DEATH Month <b>2</b> Day <b>15</b> Year <b>1966</b>		5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2-2-1894</b>		9. AGE (In years last birthday) <b>72</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <b>Lithuania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Unknown</b>	
14. MOTHER'S MAIDEN NAME <b>Unknown</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOC. A. SECURITY NO. <b>228-165620</b>		17. INFORMANT <b>Mr. Harino</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a), (b), and (c): <b>4221</b>		INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18;)		20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
21. ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b>		21. CHIEF MEDICAL EXAMINER		21. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		21. DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		21. DATE SIGNED <b>2/15/66</b>		21. EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b>		21. ADDRESS (Street, city, town, or county) <b>Baltimore MD</b>	
22. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/21/66</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St Stanislaus</b>		22d. LOCATION (City, town, or country) _____ (State) _____		23. FUNERAL DIRECTOR <b>Joseph J. Zannone, Jr.</b>		23. ADDRESS <b>265 S. Conkling St.</b>		24. REC'D BY REGISTRAR <b>MAR 1 1966</b>	
24. REGISTRAR'S SIGNATURE <b>Werner U. Spitz</b>		24. REGISTRAR'S SIGNATURE <b>Werner U. Spitz</b>		24. REGISTRAR'S SIGNATURE <b>Werner U. Spitz</b>		24. REGISTRAR'S SIGNATURE <b>Werner U. Spitz</b>		24. REGISTRAR'S SIGNATURE <b>Werner U. Spitz</b>		24. REGISTRAR'S SIGNATURE <b>Werner U. Spitz</b>		24. REGISTRAR'S SIGNATURE <b>Werner U. Spitz</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 should be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

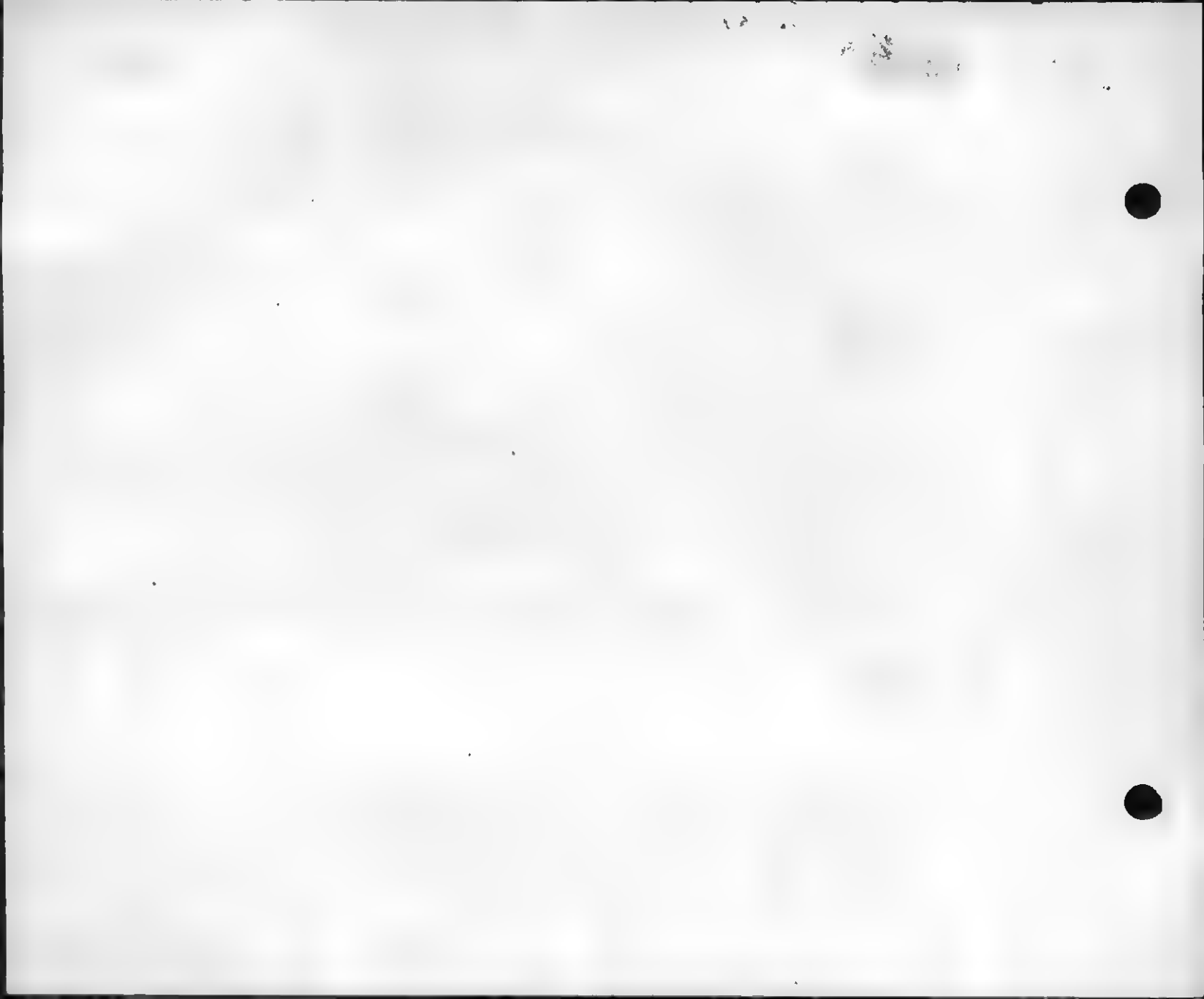


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02063 CERTIFICATE OF DEATH 1966											
1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MILFORD MANOR NURSING HOME</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> c. STREET ADDRESS <b>2628 LOVOLA SOUTHWAY</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Zelda Silverman</b>						4. DATE OF DEATH <b>Feb. 6 1966</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5/5/1894</b>		9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DOMESTIC</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>INVALID</b>		11. BIRTHPLACE (County & State, or foreign country) <b>BALTIMORE, MARYLAND</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>MOSES AARON SILVERMAN</b>						14. MOTHER'S MAIDEN NAME <b>CARRIE BUCKNER</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <b>NO</b>		17. INFORMANT <b>MR. REVELON SILVERMAN</b> Address <b>6117 TALLES ROAD</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ventricular Fibrillation</b> <b>HIC</b> DUE TO (b) <b>Rheumatic Heart Disease E.M.S.M.I. + A.S.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>Over 50 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Carcinoma left Breast c. metastasis</b>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (1) (this hospital) attended the deceased from <b>9-13-</b> , 19 <b>64</b> , to <b>2-6</b> , 19 <b>66</b> , that (1) (we) last saw the deceased alive on <b>2-6</b> , 19 <b>66</b> , and that death occurred at <b>7:15 PM</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>David I. Miller</b>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Feb. 6, 1966</b>			
22c. PHYSICIAN'S NAME (Type) <b>David I. Miller MD</b>						22d. ADDRESS <b>Lisuan Rd. Owings Mills, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				23b. DATE THEREOF <b>2/8/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HEBREW FRIENDSHIP</b>				23d. LOCATION (City, town or county) (State) <b>BALTIMORE, MARYLAND</b>	
24. FUNERAL DIRECTOR <b>Thermon &amp; Brooks</b>						ADDRESS <b>6010 Rusty Rd.</b>		25a. REC'D BY REGISTRAR <b>FEB 11 1966</b>		25b. REGISTRAR'S SIGNATURE <b>John W. Judge</b>	

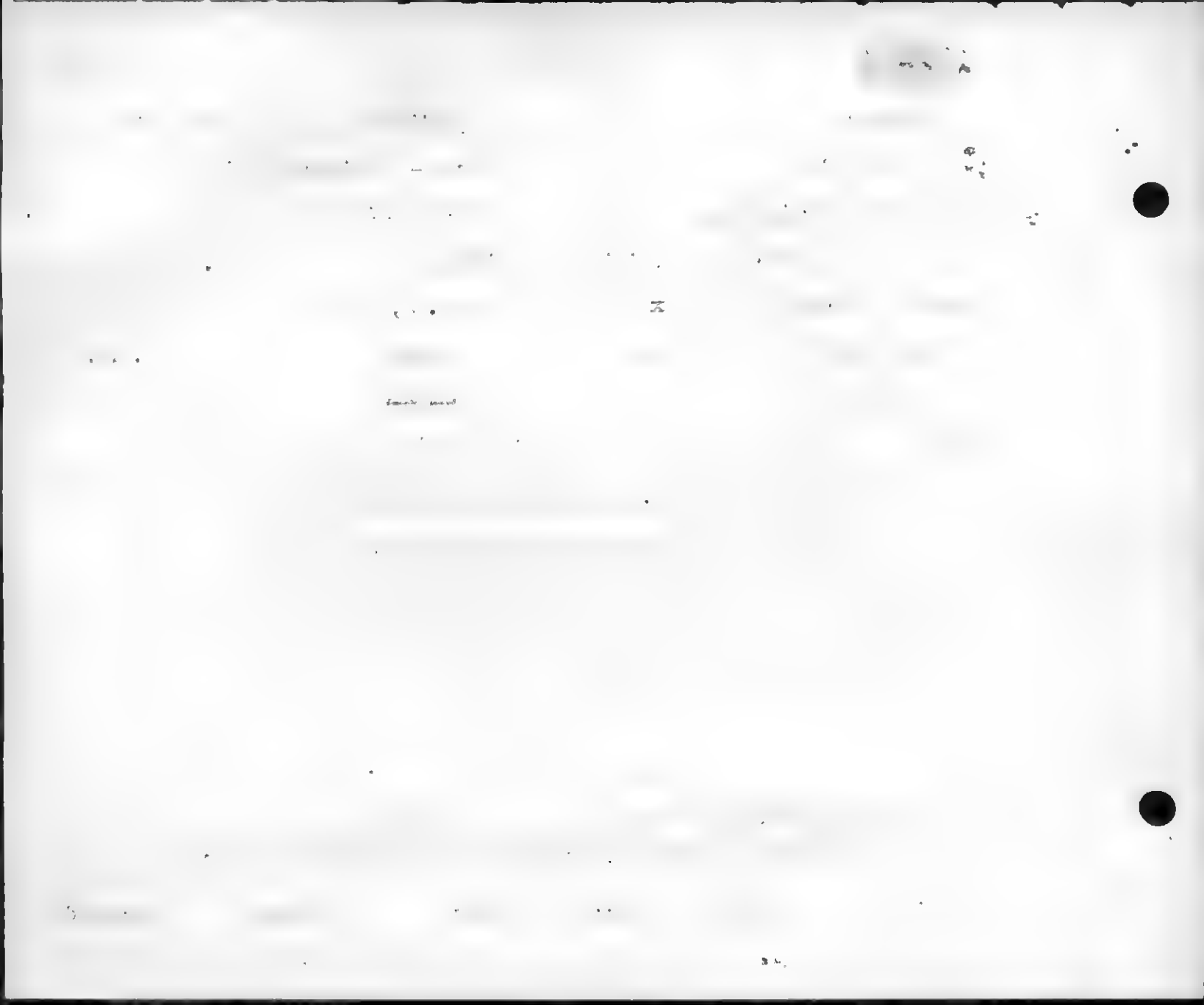


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
02064					02010						
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Randallstown</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Chapel Hill Nursing Home</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural - Baltimore 21207</b> d. STREET ADDRESS <b>3607 Durley Lane</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <b>Abbey Olivia Simms</b>			4. DATE OF DEATH <b>Feb. 19 1966</b>			5. SEX <b>Female</b>			6. COLOR OR RACE <b>White</b>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>Sept. 4, 1880</b>			9. AGE (in years last birthday) <b>85</b> yrs.			IF UNDER 1 YEAR: Months <b>19</b> Days <b>19</b> Hours <b>19</b> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>			11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>John Schmitt</b>					14. MOTHER'S MAIDEN NAME <b>unknown ANNIE BROSEKER</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>			16. SOCIAL SECURITY NO.			17. INFORMANT <b>CHRISTIAN A. SCHMIDT</b>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Semility &amp; bulbar paralysis</b> DUE TO (c) <b>Generalized Arteriosclerosis</b>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.H.F.</b>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <b>1-15-</b> , 19 <b>65</b> , to <b>2-14-</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>2-19-</b> , 19 <b>66</b> , and that death occurred at <b>10 P.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Cesar Valle Caverio</b>					22b. DATE SIGNED <b>2-20-66</b>		22c. PHYSICIAN'S NAME (Type) <b>CESAR VALLE CAVERO</b>				
22d. ADDRESS <b>8629 Liberty Rd.</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>2/23/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Woodlawn Maryland</b>				
24. FUNERAL DIRECTOR <b>Mac Galt &amp; Son</b>			25a. REC'D BY REGISTRAR <b>Frederick Wade</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>FEB 23 1966</b>				



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02065

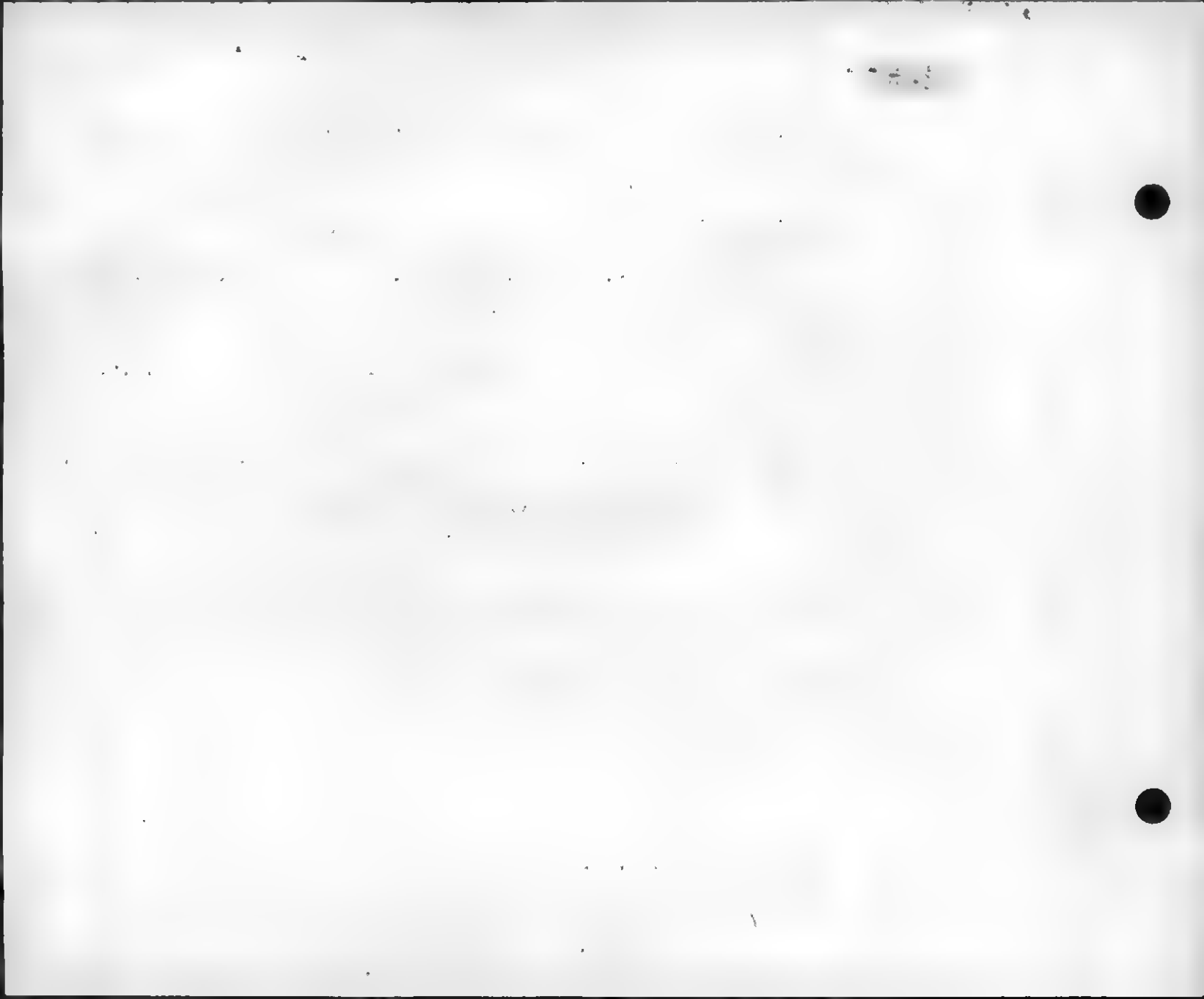
## CERTIFICATE OF DEATH

02011

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PORT HOWARD</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		d. STREET ADDRESS <b>2533 SYCAMORE AVENUE</b>	
3. NAME OF DECEASED (Type or print) First <b>HAYWARD</b> Middle <b>W.</b> Last <b>SINGLE, SR.</b>		4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>18</b> Year <b>1966</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 18, 1919</b>
9. AGE (In years last birthday) <b>46</b> yrs		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PAINTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOUSE</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JAMES SINGLE</b>		14. MOTHER'S MAIDEN NAME <b>MARY JOHNSON</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW II</b>		16. SOCIAL SECURITY NO. <b>217 01 4433</b>	
17. INFORMANT <b>CLIN RECORDS VA HOSPITAL, FT HOWARD, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>BRONCHOGENIC CARCINOMA WITH METASTASES TO BRAIN AND MEDIASTINAL LYMPH NODES</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>1 MONTH</b> (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <del>the</del> (this hospital) attended the deceased from <b>2/11/66</b> , 19__, to <b>2/18/66</b> , 19__, that <del>the</del> (we) last saw the deceased alive on <b>2/18/66</b> , 19__, and that death occurred <b>5:30A M.</b> from causes and on the date stated above.			
22a. SIGNATURE <i>Milton Ginsberg</i>		22b. DATE SIGNED <b>2/18/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>MILTON GINSBERG, M. D.</b>		22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMEMORIAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>2-23-1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>	23d. LOCATION (City or town) (County) (State) <b>BALTIMORE MARYLAND</b>
24. FUNERAL DIRECTOR <b>E.O. Wilson</b>		25. REC'D BY REGISTRAR <b>Elroy O. Wilson Funeral Home</b> ADDRESS <b>Orleans St. Baltimore, Md.</b>	
26. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE <b>FEB 23 1966</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, at any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

02066

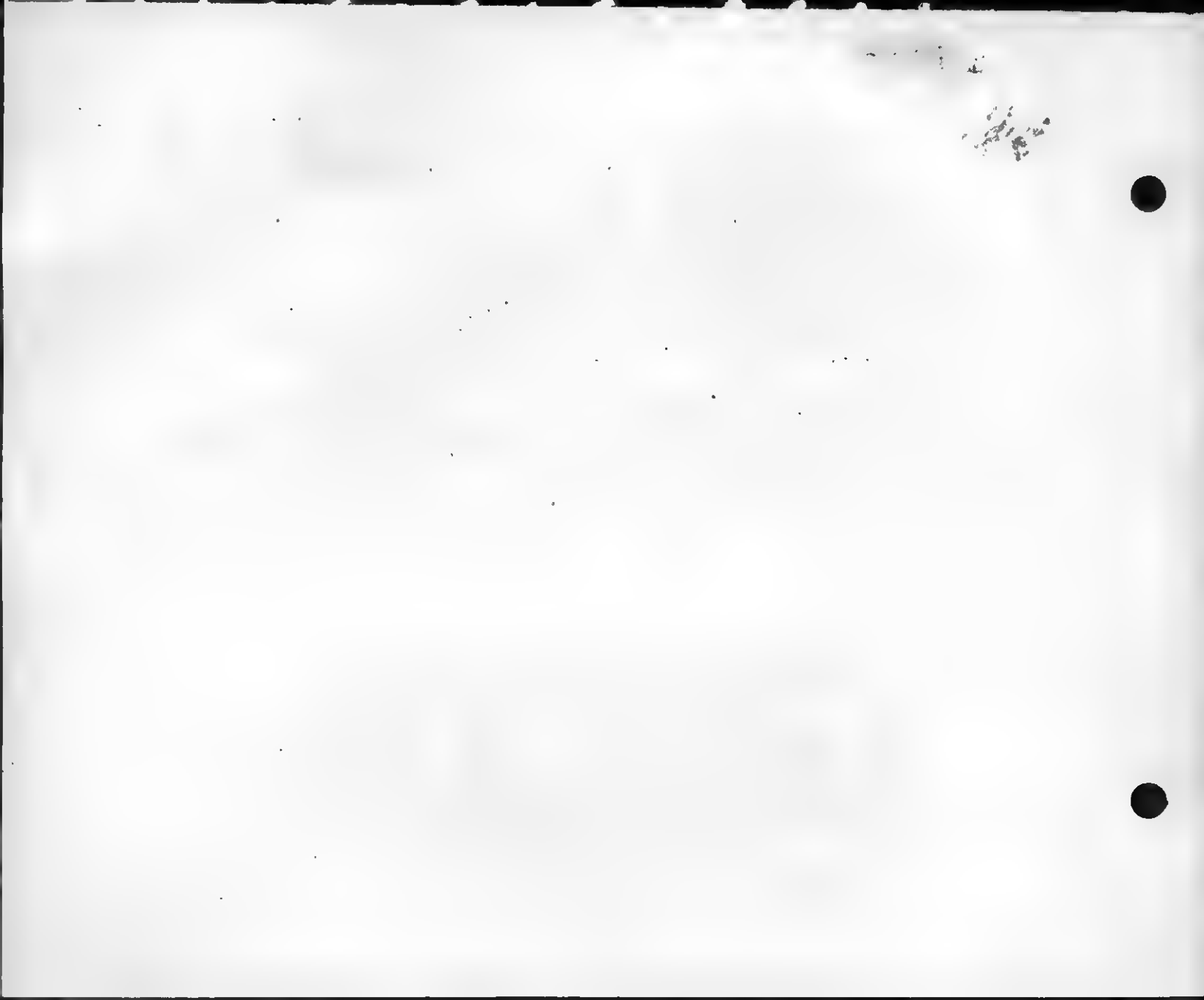
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02012

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RURAL</u>		c. LENGTH OF STAY IN 1b <u>20 YEARS</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE GLEN ARM.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>VILLA MARIA, NOTHCLEIFF</u>				d. STREET ADDRESS <u>VILLA MARIA, NOTHCLEIFF</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>SISTER MARY ADA SKIFFINGTON</u>				4. DATE OF DEATH Month <u>FEB</u> Day <u>20</u> Year <u>1966</u>			
5. SEX <u>F.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>AUG 18 1886</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TEACHER</u>		11. BIRTHPLACE (County & State, or foreign country) <u>PHILADELPHIA, PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>THOMAS SKIFFINGTON</u>				14. MOTHER'S MAIDEN NAME <u>MARY RUSSELL</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>(If yes give war or dates of service)</u>		17. INFORMANT <u>S. MARIE PERPETUA VILLA MARIA NOTHCLEIFF</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Blindness, TOTAL</u> DUE TO (c) <u>DIABETES M.</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>DEC. 30, 1965</u> to <u>FEB 20, 1966</u> , that (I) (we) last saw the deceased alive on <u>DEC 30 1965</u> , and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>A.E. WALSH</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>A.E. WALSH</u>				22d. ADDRESS <u>715 N. CHARLES ST.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>FEB 23, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>SISTERS CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>GLEN ARM, MARYLAND</u>	
24. FUNERAL DIRECTOR <u>RAYMOND J. CURRAN</u>		25a. REC'D BY REGISTRAR <u>817 SCARLETT DRIVE TOWSON, MARYLAND 21204</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>		DATE <u>MAR 3 1966</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02067

## CERTIFICATE OF DEATH

Reg. Dist. No.

02013

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SHANGRI-LA NURSING HOME</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>EDITH</b> Middle <b>P.</b> Last <b>SMALL</b>		4. DATE OF DEATH Month <b>2</b> - Day <b>6</b> - Year <b>1966</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEBRUARY 13, 1887</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years lost birthday) yrs. <b>78</b>
11. BIRTHPLACE (State or foreign country) <b>MECKLENBURG CO., VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>UNKNOWN</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>-----</b>	
17. INFORMANT <b>MRS. ELINOR W. EDEL, PROSPECT PLANTATION, MD.</b>		Address <b>GRASONVILLE, XX.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarct</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. ft. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>2-28-1966</b> to <b>2-6-1966</b> , that I last saw the deceased alive on <b>2-6-1966</b> , and that death occurred at _____ M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Cesar Valle Caverio</b> M.D. <b>8629 Randallstown</b>		DATE SIGNED <b>2-6-66</b>	
PHYSICIAN'S NAME (Type) <b>CESAR VALLE CAVERO</b>		<b>MARYLAND</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>2.9.66</b>	22c. NAME OF CEMETERY OR CREMATORY <b>LOUDDON PARK CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>HUBBARD FUNERAL HOME, 4107 WILKENS AVE. 21229</b>		24a. REC'D BY REGISTRAR <b>FEB 9 1966</b>	
24b. REGISTRAR'S SIGNATURE			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

# MARYLAND STATE DEPARTMENT OF HEALTH

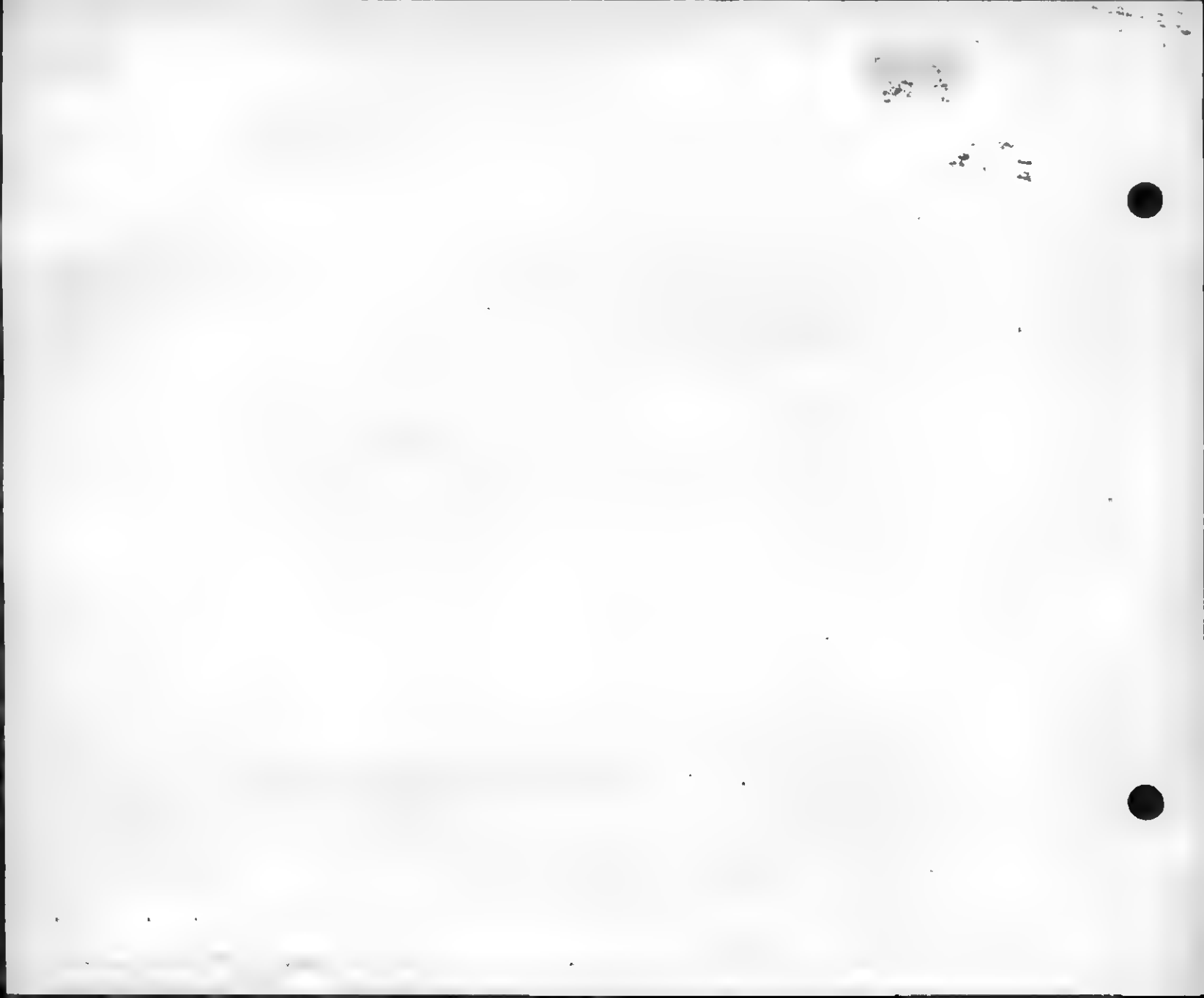
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02068

## CERTIFICATE OF DEATH

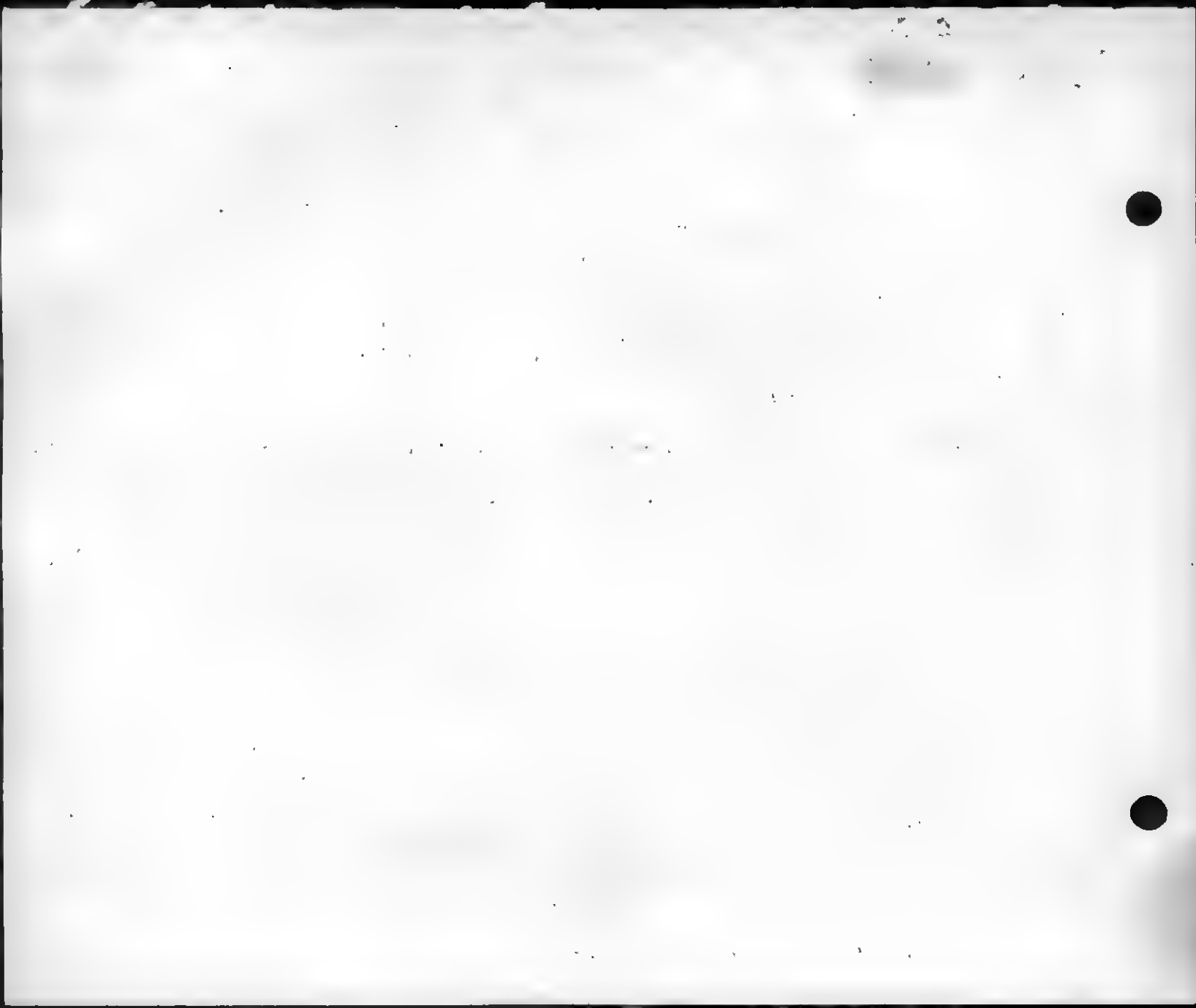
02014

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mount Wilson</b>		c. LENGTH OF STAY IN 1b <b>2 months</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edgewater</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Mount Wilson State Hospital</b>				d. STREET ADDRESS <b>-----</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ANNIE</b> Middle <b>M.</b> Last <b>SMITH</b>			4. DATE OF DEATH Month <b>Feb.</b> Day <b>2</b> Year <b>1966</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-19-73</b>	9. AGE (In years last birthday) <b>92</b> yrs.	IF UNDER 1 YEAR Months <b>92</b> Days <b>92</b> Hours <b>92</b> Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>our home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Edgewater, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Lee</b>			14. MOTHER'S MAIDEN NAME <b>Susan Crutchley</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Hosp. records, Mt. Wilson St. Hospital</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart disease</b> <b>4200</b> DUE TO <b>2 Auricular Fibrillation</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Moderately Advanced Pulmonary Tuberculosis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>3 mo.</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>					
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12-3-</b> , 1965, to <b>2-2-</b> , 1966, that (I) (we) last saw the deceased alive on <b>2-2-</b> , 1966, and that death occurred at <b>12:15</b> AM, from the causes and on the date stated above.							
22a. SIGNATURE <b>Wm. Newcomer</b>				22b. DATE SIGNED <b>2-2-66</b>		22c. PHYSICIAN'S NAME (Type) <b>Wm. Newcomer, M.D., Superintendent</b>	
22d. ADDRESS <b>Mount Wilson, Maryland</b>				22e. ADDRESS <b>Mount Wilson, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/5/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Edwards Chapel</b>		23d. LOCATION (City, town or county) (State) <b>Parole, An. Co. Md.</b>	
24. FUNERAL DIRECTOR <b>Hopping E. Hopping</b>				25a. REC'D BY REGISTRAR <b>FEB 7 1966</b>		25b. REGISTRAR'S SIGNATURE <b>John Charles Judge</b>	



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 02069 CERTIFICATE OF DEATH 02015									
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 21206</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>					d. STREET ADDRESS <b>4434 Springwood Ave.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Henry</b> Middle <b>J.</b> Last <b>Smith</b>					4. DATE OF DEATH <b>February 2 19 66</b>				
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6/26/91</b>		9. AGE (In years last birthday) <b>74</b> yrs. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Penna. R. Rd.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Balto. Md.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>August Smith</b>					14. MOTHER'S MAIDEN NAME <b>Augusta Smith</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes give war or dates of service)			16. SOCIAL SECURITY NO. <b>717-07-8271</b>		17. INFORMANT <b>Mrs. Frances A. Smith-4434 Springwood Ave.</b> Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> <b>332X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying causa last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <b>January 20, 19 66</b> to <b>February 19 66</b> that (I) (we) last saw the deceased alive on <b>February 2 19 66</b> , and that death occurred at <b>9:30 PM</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>Teodoro R. Carangal</b> M.D.					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>2-2-66</b>		
22c. PHYSICIAN'S NAME (Type) <b>Teodoro R. Carangal</b>					22d. ADDRESS <b>7620 York Rd. Baltimore, Md. 21204</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/5/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Balto. Md.</b>		
24. FUNERAL DIRECTOR <b>John C. Miller Inc-6415 Belair Rd.-21206</b> ADDRESS					25a. REC'D BY REGISTRAR <b>FEB 8 1966</b> DATE		25b. REGISTRAR'S SIGNATURE <b>J. Judge</b>		



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02016

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b> c. LENGTH OF STAY IN 1b <b>7 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> d. STREET ADDRESS <b>515 CUMBERLAND STREET</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JESSE</b> Middle <b>--</b> Last <b>SMITH</b>		4. DATE DEATH <b>FEBRUARY 24 19 66</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 11, 1898</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>UPHOLSTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>UPHOLSTERY SHOP</b>	9. AGE (In years last birthday) <b>67</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (County & State, or foreign country) <b>AUGUSTA, GEORGIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JESSE R. SMITH</b>		14. MOTHER'S MAIDEN NAME <b>NAOMI PRESTON</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW I</b>		16. SOCIAL SECURITY NO. <b>218 32 4690</b>	
17. INFORMANT <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY EDEMA</b> 7200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>  <b>UNKNOWN</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from <b>2/17/66</b> , 19 <b>66</b> , to <b>2/24/66</b> , 19 <b>66</b> , that (we) last saw the deceased alive on <b>2/24/66</b> , 19 <b>66</b> , and that death occurred at <b>6:05 AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Neilon Neilson, M.D.</b>		22b. DATE SIGNED <b>2/24/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>NEILON NEILSON, M.D.</b>		22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>2-28-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>	23d. LOCATION (City, town or county) (State) <b>BALTIMORE, MD.</b>
24. FUNERAL DIRECTOR <b>Charles A. K...</b>		25a. REC'D BY REGISTRAR <b>Feb 25 1966</b> DATE 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

02071

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02017

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 6 Mo.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Dulaney Valley Towson N. Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown, Md.	
f. STREET ADDRESS 413 Main St.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Mary Lavinia Zepp Smith		4. DATE OF DEATH Month Day Year Feb 20 1966	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2, 17, 1900
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Mins. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Carroll Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Louis Lee Zepp		14. MOTHER'S MAIDEN NAME Lola B. Miller	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. <del>4</del>	
17. INFORMANT Mrs. Mary M. Dunton, 635 Piccadilly Rd. #4		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory infection</i> 38 DUE TO (b) <i>Multiple excisions of colon</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITION CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Cerebral arteriosclerosis with thrombosis, st.</i>		INTERVAL BETWEEN ONSET AND DEATH 8 months 2 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>July 3, 1965</i> , to <i>Feb 20, 1966</i> , that (I) (we) last saw the deceased alive on <i>Feb 18, 1966</i> , and that death occurred at <i>4:30 PM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Frederick J. Vollmer</i>		22b. DATE SIGNED <i>Feb 20, 1966</i>	
22c. PHYSICIAN'S NAME (Type) FREDERICK J. VOLLMER		22d. ADDRESS 6100 YCPK RD, BALTIMORE MD 21212	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2, 23, 66	
23c. NAME OF CEMETERY OR CREMATORY Druid Ridge		23d. LOCATION (City, town or county) (State) Baltimore, Md. MESSY, MD.	
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, Towson, Md.		25a. REC'D BY REGISTRAR DATE FEB 24 1966	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

100



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

020772

02018

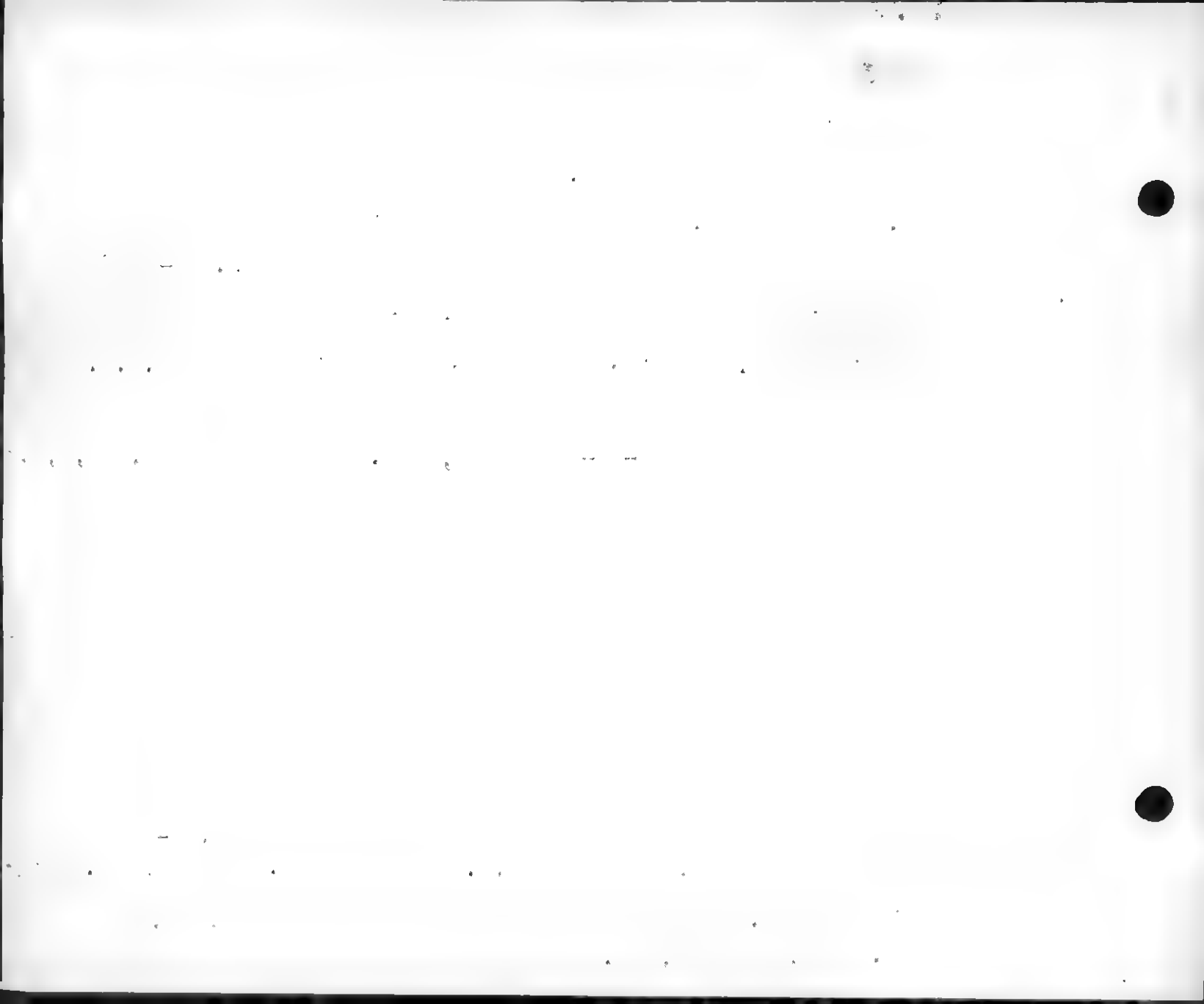
FOR STATE HEALTH DEPT.

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <b>Maryland</b> b COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>		c LENGTH OF STAY N 1b <b>Hrs. ??</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>600 S. 46 th Street, 21222</b>		e STREET ADDRESS <b>6815 Fait Avenue 21224</b>	
3 NAME OF DECEASED (Type or print) <b>MICHAEL SMUTKO</b>		4 DATE OF DEATH <b>Feb. 3-1966</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Aug. 31-1908</b>
9 AGE (in years, month, day) <b>57 yrs</b>		10 IF UNDER YEAR IF UNDER 24 HRS Months Days Hours Min	
11a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sanitation Dept.</b>		11b KIND OF BUSINESS OR INDUSTRY <b>Baltimore City</b>	
12 BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		13 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14 FATHER'S NAME <b>Not known</b>		15 MOTHER'S MAIDEN NAME <b>Not known</b>	
16 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		17 SOCIAL SECURITY NO <b>167-01-9624</b>	
18 INFORMANT <b>Wife, Mrs. Margaret Smutko, #2, a, b, c</b>		Address	
19 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY <b>491 X</b> IMMEDIATE CAUSE (a) <b>aspiration pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>HAx Ach Pleur</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural cause <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Theodore C. Patterson</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Theodore C. Patterson M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>Feb. 7-1966</b>	
23c NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith</b>		23d LOCATION (City or town) (County) (State) <b>Baltimore, Md.</b>	
24 FUNERAL DIRECTOR <b>JOHN J. DUDA, Dundalk, Md. 21222</b>		25a REC'D BY REGISTRAR <b>FEB 7 1966</b>	
25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>		22 DATE SIGNED <b>Feb. 4-1966</b>	

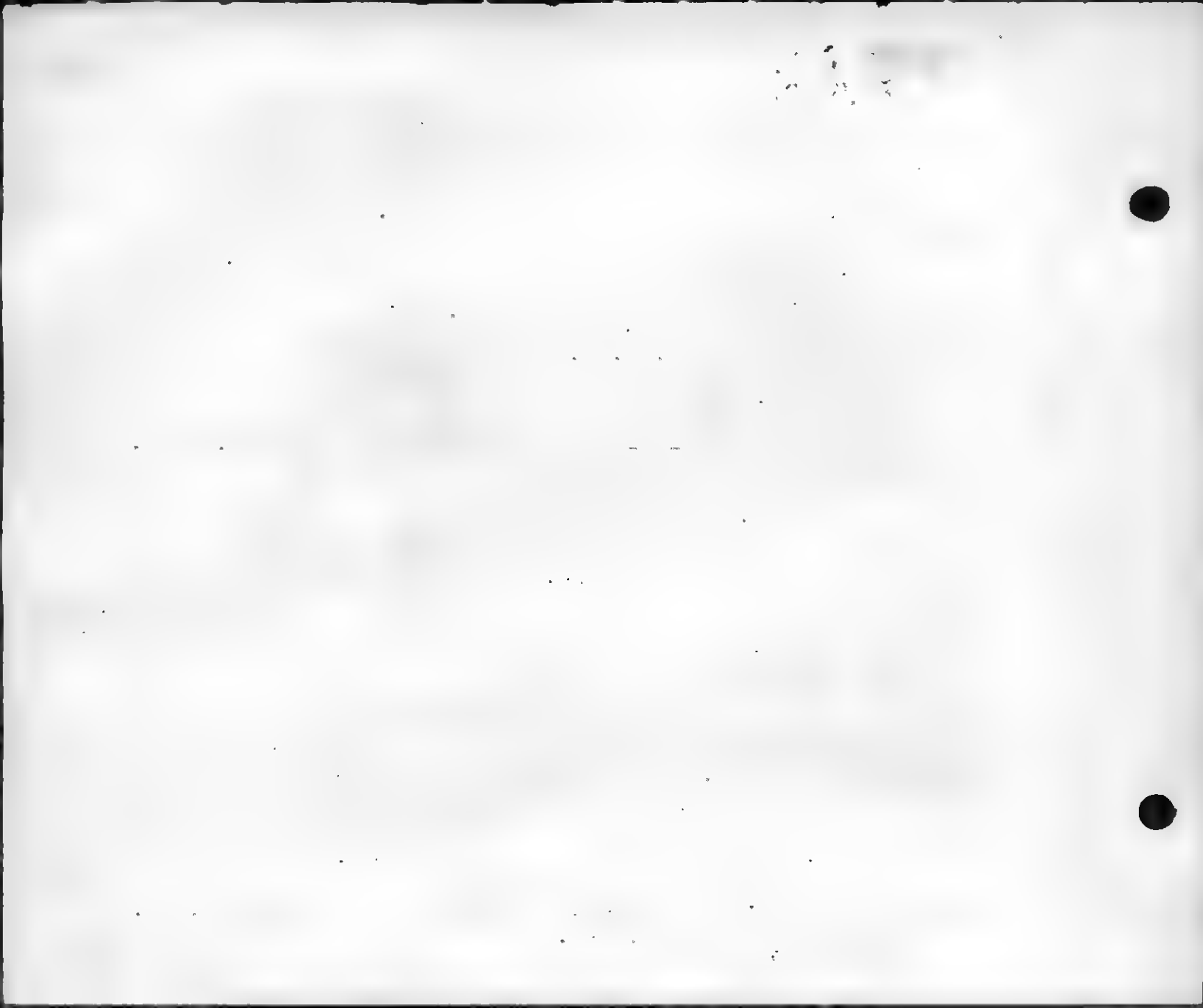


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should be notified of the death of the deceased, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY IN 1D <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>St. Joseph Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>✓</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>1003 E. Belvedere Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) <u>Melvin John Stevens</u> First Middle Last				<b>4. DATE OF DEATH</b> Month <u>Feb.</u> Day <u>4</u> Year <u>1966</u>				<b>5. SEX</b> <u>Male</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>Jan. 1, 1910</u> <b>9. AGE</b> (in years last birthday) <u>56</u> yrs. <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Elevator Agent</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Pa. R. R.</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Baltimore Maryland</u> <b>12. CITIZEN OF WHAT COUNTRY?</b>			
<b>13. FATHER'S NAME</b> <u>Lawrence C. Stevens</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Jochheim</u>							
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <u>717-07-9561</u>				<b>17. INFORMANT</b> <u>Elsie Kennedy Stevens, wife, above</u> Address			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <u>Cirrhosis of liver</u> <u>5810</u> <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> <b>(b)</b> <u>Bleeding esophageal varices</u> <b>(c)</b> <u>Confluent broncho-pneumonia, bilateral</u>											
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b>				<b>(County)</b>				<b>(State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Jan. 27</u> , 19 <u>66</u> , <b>to</b> <u>Feb. 4</u> , 19 <u>66</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>Feb. 4</u> , 19 <u>66</u> , <b>and that death occurred at</b> <u>10:30</u> p.m., <b>from the causes and on the date stated above.</b>											
<b>22a. SIGNATURE</b> <u>Govindo Rao</u>				<b>22b. DATE SIGNED</b> <u>February 5, 1966</u>				<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Govindo Rao, M.D.</u>			
<b>22d. ADDRESS</b> <u>7620 York Road, 21204</u>				<b>22e. ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/>							
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>2/8/66</u>				<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Parkwood Cemetery</u>			
<b>23d. LOCATION (City, town or county)</b> <u>Baltimore, Md.</u>				<b>23e. (State)</b>							
<b>24. FUNERAL DIRECTOR</b> <u>Schimunek Funeral Home, Inc.</u> <u>3331 Brehms Lane</u>				<b>25a. REC'D BY REGISTRAR</b> DATE <u>Feb 7 1966</u>				<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

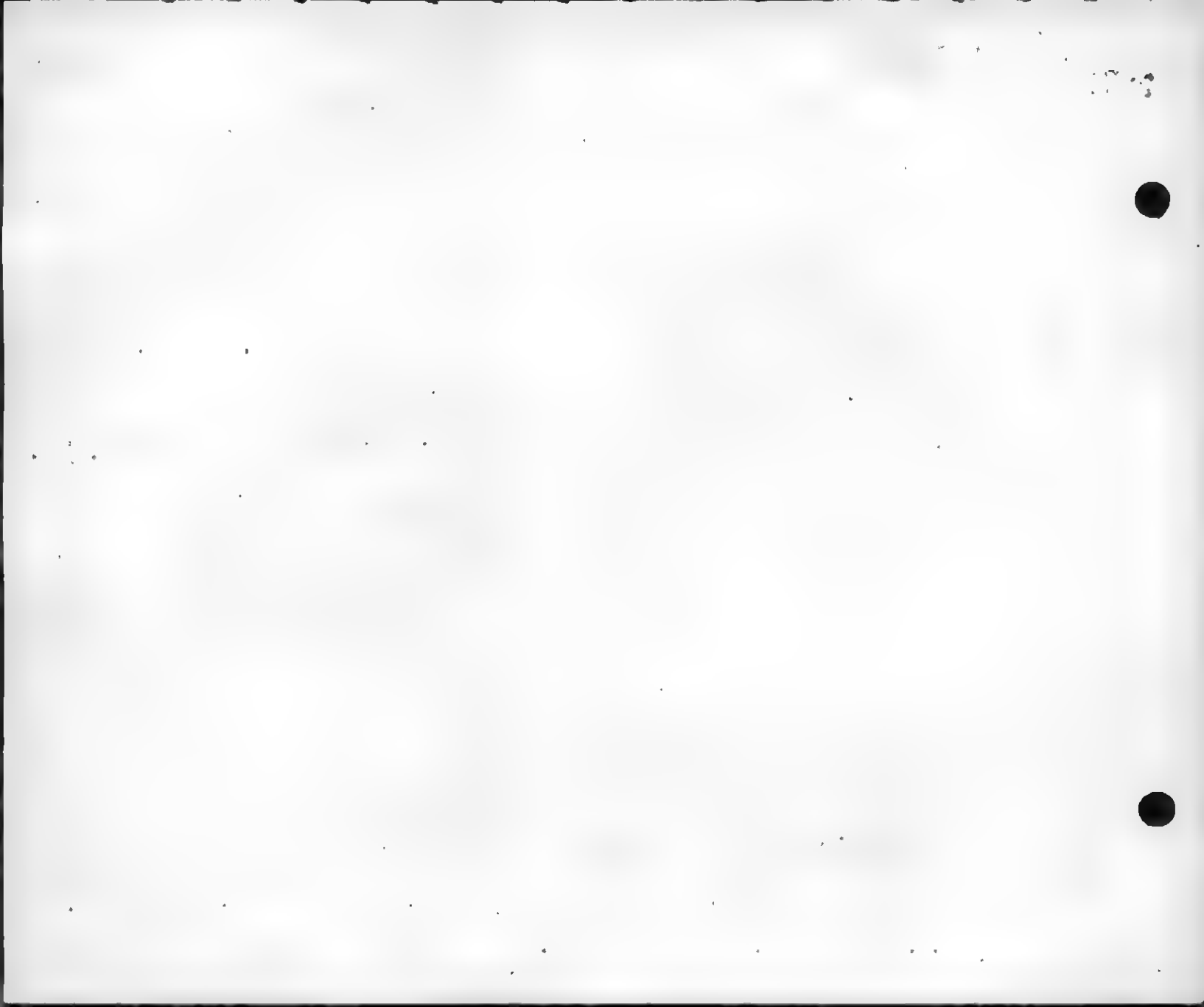
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02074

02021

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore 7,</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>7110 Rockridge Road</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore 7</b> d. STREET ADDRESS <b>7110 Rockridge Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Evalyn</b> <b>Stevenson</b> First Middle Last		4. DATE OF DEATH <b>February 28, 1966</b> Month Day Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 23, 1906</b>
9. AGE (In years last birthday) <b>59</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Carroll County, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Claude T. Matthews</b>		14. MOTHER'S MAIDEN NAME <b>Eurydice Shaeffer</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>George E. Stevenson, 7110 Rockridge Rd., Baltimore 7, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>METASTATIC ADENOCARCINOMA FROM LARGE BOWEL</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 15, 1966</b> to <b>2-28, 1966</b> , that (I) (we) last saw the deceased alive on <b>2-27, 1966</b> , and that death occurred at <b>12 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Frank G. Kuehn</b>		22b. DATE SIGNED _____	
22c. PHYSICIAN'S NAME (Typed) <b>FRANK G. KUEHN</b>		22d. ADDRESS <b>721 MED ARTS BLDG.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>March 3, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley Gardens</b>	23d. LOCATION (City, town or county) (State) <b>Baltimore, County, Md.</b>
24. FUNERAL DIRECTOR <b>J.F.Eline &amp; Sons, Reisterstown, Md.</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and no any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02075

## CERTIFICATE OF DEATH

02022

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Florida</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Baltimore</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bragenton</u>			
c. LENGTH OF STAY IN 1b <u>7 mo.</u>				d. STREET ADDRESS <u>1203 Arlands Ave</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Foxleigh Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Hazel Stratton</u>				4. DATE OF DEATH Month Day Year <u>2 9 1966</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-15-1887</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clothing buyer</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Loris Stephey</u>				14. MOTHER'S MAIDEN NAME <u>Janie Young</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>214-01-6037</u>			
				17. INFORMANT Address <u>Mr. Seybert B. Stratton same address</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 4500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis - generalized</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>June 29, 1965</u> to <u>February 9, 1966</u> that (I) (we) last saw the deceased alive on <u>February 9, 1966</u> , and that death occurred at <u>2:55 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Carroll E. McWilliams</u> M.D.				22b. DATE SIGNED <u>2-9-66</u>			
22c. PHYSICIAN'S NAME (Type) <u>Carroll E. McWilliams</u>				22d. ADDRESS <u>Bresterstone Key, Conn.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/14/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Mausoleum</u>		23d. LOCATION (City, town or county) (State) <u>Weclawn, Md.</u>	
24. FUNERAL DIRECTOR <u>Wm. J. Tidner &amp; Son</u> ADDRESS <u>Baltimore, Md. 17</u>				25a. REC'D BY REGISTRAR <u>Charles J. J...</u> 25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>			
				DATE <u>FEB 14 1966</u>			

1944

1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the research. It also mentions the scope of the study and the methods used.

2. The second part of the report is a detailed description of the experimental work. It includes a description of the apparatus used, the procedure followed, and the results obtained. It also discusses the errors and limitations of the experiment.

3. The third part of the report is a discussion of the results. It compares the results with the theoretical predictions and with the results of other experiments. It also discusses the implications of the results and the conclusions drawn from the study.

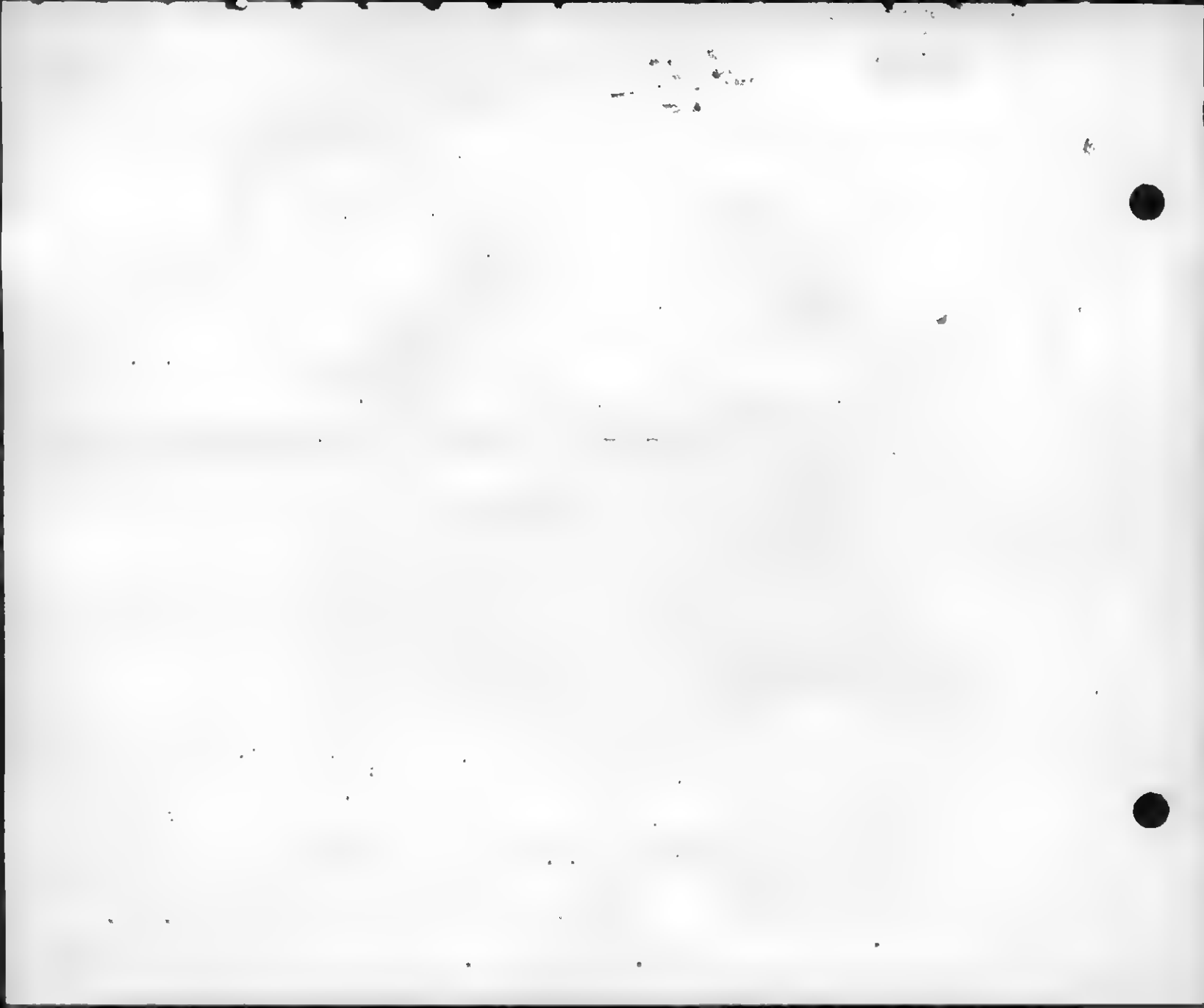
4. The fourth part of the report is a conclusion. It summarizes the main findings of the study and states the conclusions drawn from the results. It also mentions the limitations of the study and suggests directions for further research.



TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the **final** certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

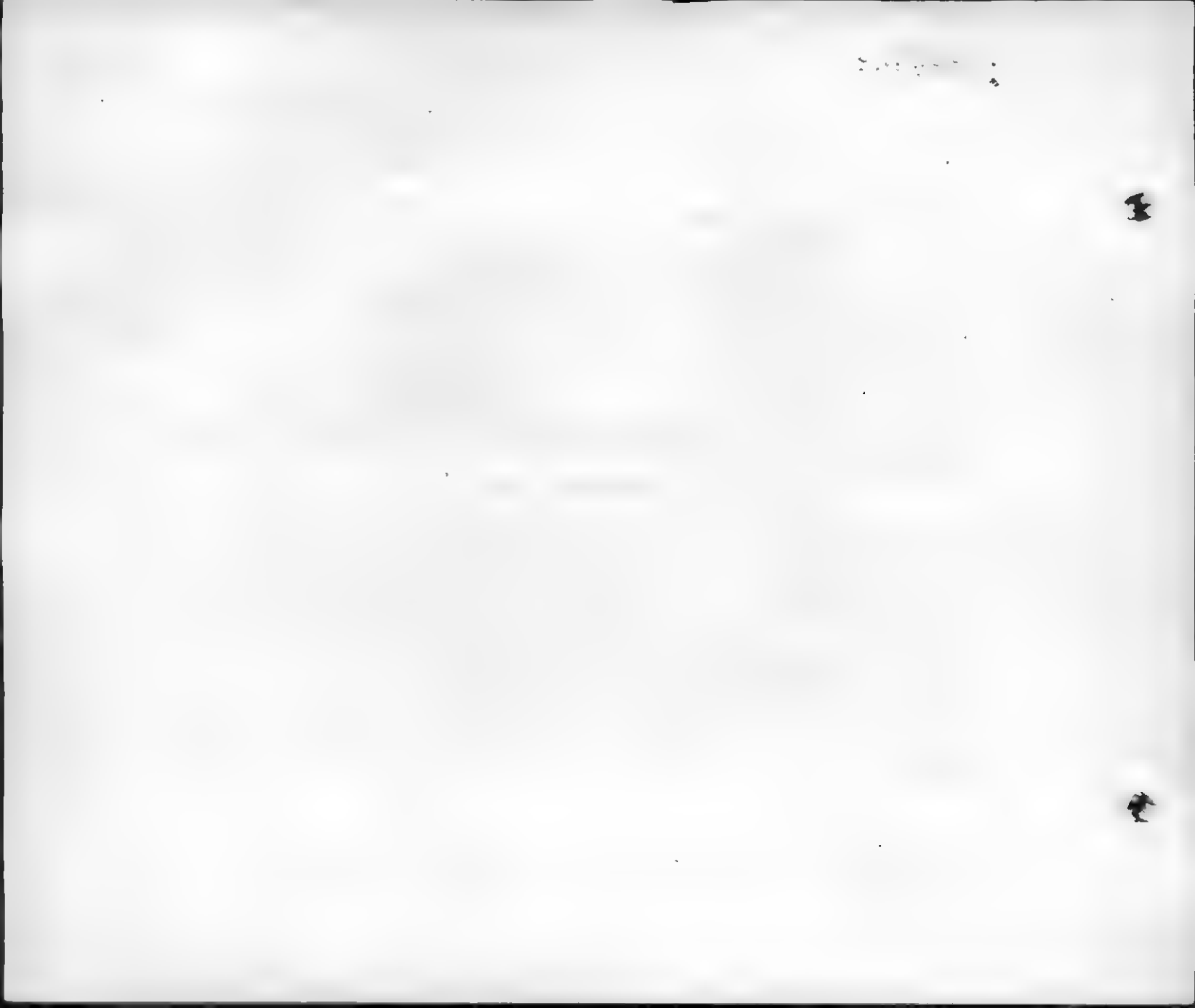
MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>5mth27dys</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>						e. STREET ADDRESS <b>7406 School Lane</b>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Ida</b>		First		Middle		Last		4. DATE OF DEATH <b>February 28 1966</b>	
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1899</b>		9. AGE (in years last birthday) <b>76</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
13. FATHER'S NAME <b>unknown Alexander Powichroski</b>				14. MOTHER'S MAIDEN NAME <b>unknown</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>unknown</b>				16. SOCIAL SECURITY NO. <b>216-20-3084</b>		17. INFORMANT <b>Eleanor Esteppe</b> Address <b>7406 School Lane</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerosis, generalized and severe</b> <b>4500</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Malnutrition</b>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Aug. 31 1965</b> to <b>Feb. 28 1966</b> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <b>Feb. 28 1966</b> , and that death occurred at <b>11:45</b> M, from the causes and on the date stated above.									
22a. SIGNATURE <b>Stella Wachslar</b>		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2-28-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M.D.</b>		22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/4/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Rosary Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore Co. Md.</b>			
24. FUNERAL DIRECTOR <b>John M. Weber &amp; Sons Inc</b>		ADDRESS <b>401 S. Chester St.</b>		25a. REC'D BY REGISTRAR <b>DATE MAR 2 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



1  
02077  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
02024

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MONKTON</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MONKTON</b>	
c. LENGTH OF STAY IN 1b <b>43 years</b>		d. STREET ADDRESS <b>OLD YORK ROAD</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR UNKNOWN <b>OLD YORK ROAD</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ROSS</b> Middle <b>TROYER</b> Last <b>SUTTON</b>		4. DATE OF DEATH Month <b>February</b> Day <b>13</b> Year <b>1966</b>	
5 SEX <b>MALE</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>JUNE 28, 1884</b>
9 AGE (In years last birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Agriculture</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>LUTHER SUTTON</b>		14. MOTHER'S MAIDEN NAME <b>ALVERTA TROYER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>219-36-0275</b>	
17. INFORMANT <b>WIFE</b> Address <b>OLD YORK RD MONKTON</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMATOSIS - generalized</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>	
DUE TO (b) <b>10 Carcinoma of The liver.</b>			
DUE TO (c) <b></b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <b>October 10 - 1965</b> to <b>FEB 13</b> , 1966, that (I) last saw the deceased alive on <b>FEB 12</b> , 1966, and that death occurred <b>5:00 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Henry L. McCorckle</b> M.D.		22b. DATE SIGNED <b>2/13/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Henry L. McCorckle MD</b>		22d ADDRESS <b>JARRETTSVILLE HKE Phoenix Md</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b DATE THEREOF <b>2/16/1966</b>	23c NAME OF CEMETERY OR CREMATORY <b>CHESTNUT GROVE</b>	23d. LOCATION (City, town, or county) (State) <b>JACKSONVILLE MD.</b>
24 FUNERAL DIRECTOR'S SIGNATURE <b>Charles E. Kutz</b>		25a REC'D BY REGISTRAR <b>FEB 15 1966</b>	
ADDRESS <b>Jarrettsville, Md.</b>		25b REGISTRAR'S SIGNATURE <b>Charles E. Kutz</b>	

Def



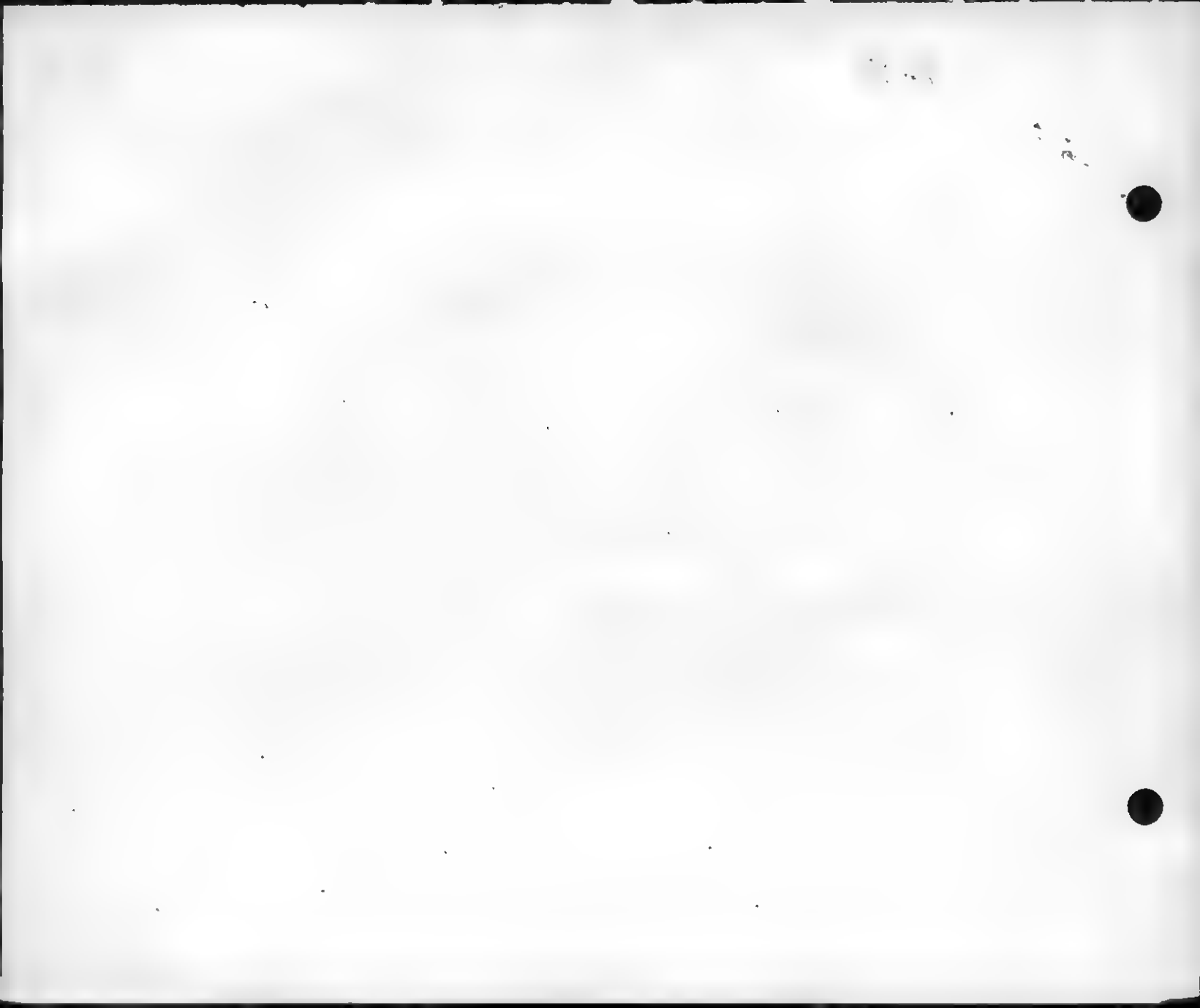
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>BALTO</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>		c. LENGTH OF STAY IN 1b <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD</b>		b. COUNTY <b>BALTO</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>FOREST HAVEN</b>						e. STREET ADDRESS <b>3771 North Point Rd.</b>					
3. NAME OF DECEASED (Type or print) <b>ELEANOR TALLEY</b>						4. DATE OF DEATH <b>FEB 2 1966</b>					
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7/8/90</b>		9. AGE (in years last birthday) <b>75</b> yrs.		IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <b>England</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>AMOS WARNER</b>						14. MOTHER'S MAIDEN NAME <b>DAVIS</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>HOSPITAL RECORDS</b>				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>MYOCARDIAL INFARCTION</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
INTERVAL BETWEEN ONSET AND DEATH											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <b>1/1</b> , 1966, to <b>2/1</b> , 1966, that (I) (we) last saw the deceased alive on <b>2/1</b> , 1966, and that death occurred at <b>M</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>E. S. MacNabb</b>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2/4/66</b>			
22c. PHYSICIAN'S NAME (Type) <b>E. S. MacNabb</b>						22d. ADDRESS <b>301 Frederick Rd.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>2/8, 66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>OAK LAWN</b>				23d. LOCATION (City, town or county) (State) <b>BALTO CO. MD</b>			
24. FUNERAL DIRECTOR <b>E. S. MacNabb</b>						25a. REC'D BY REGISTRAR <b>2-39</b>		25b. REGISTRAR'S SIGNATURE <b>1966</b>			

21238



FOR STATE  
HEALTH DEPT

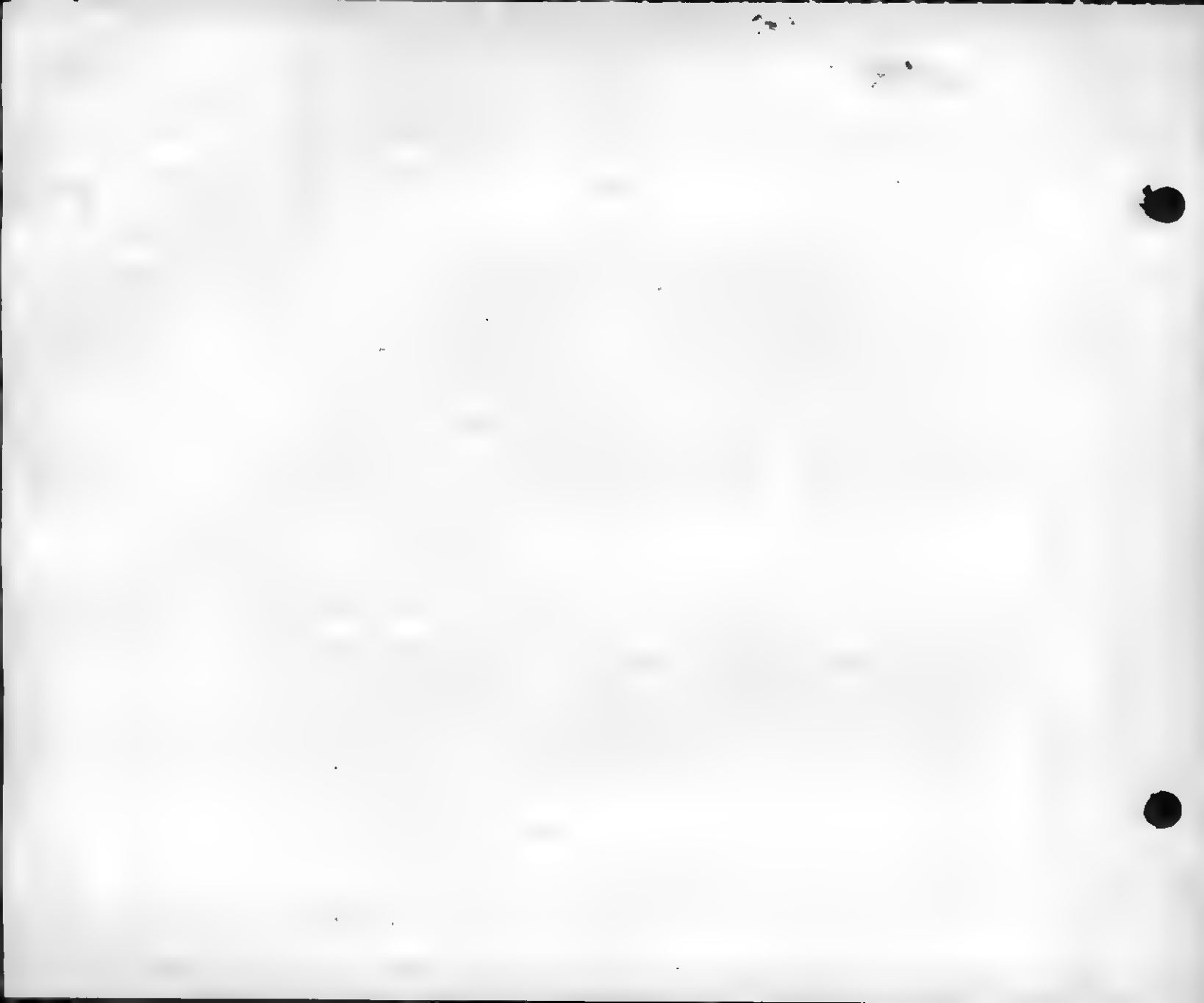
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02026

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural- Parkton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural- Freeland</u>	
c. LENGTH OF STAY IN 1b <u>Minutes</u>		d. STREET ADDRESS <u>Freeland Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>York Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Benson E. Tawney, Jr.</u>		4. DATE OF DEATH <u>Feb. 4</u> 1966	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 29, 1908</u> 57 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Highway Dept.</u>	
11. BIRTHPLACE (State or foreign country) <u>Butler, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Luther Klinefelter</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212-20 9542</u>	
17. INFORMANT <u>Benson E. Tawney, Jr.</u>		Address <u>Maryland Line, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>A. M. France</u>		22. DATE SIGNED <u>2/4/66</u>	
EXAMINER'S NAME (Type) <u>A. M. FRANCE</u>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>Feb 7, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Dover Meth. Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Butler, Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>Spauld Hartenstein, New Freedom, Pa.</u>		25a. REC'D BY REGISTRAR <u>Feb 3 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>John L. Judd</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. It may be delayed if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

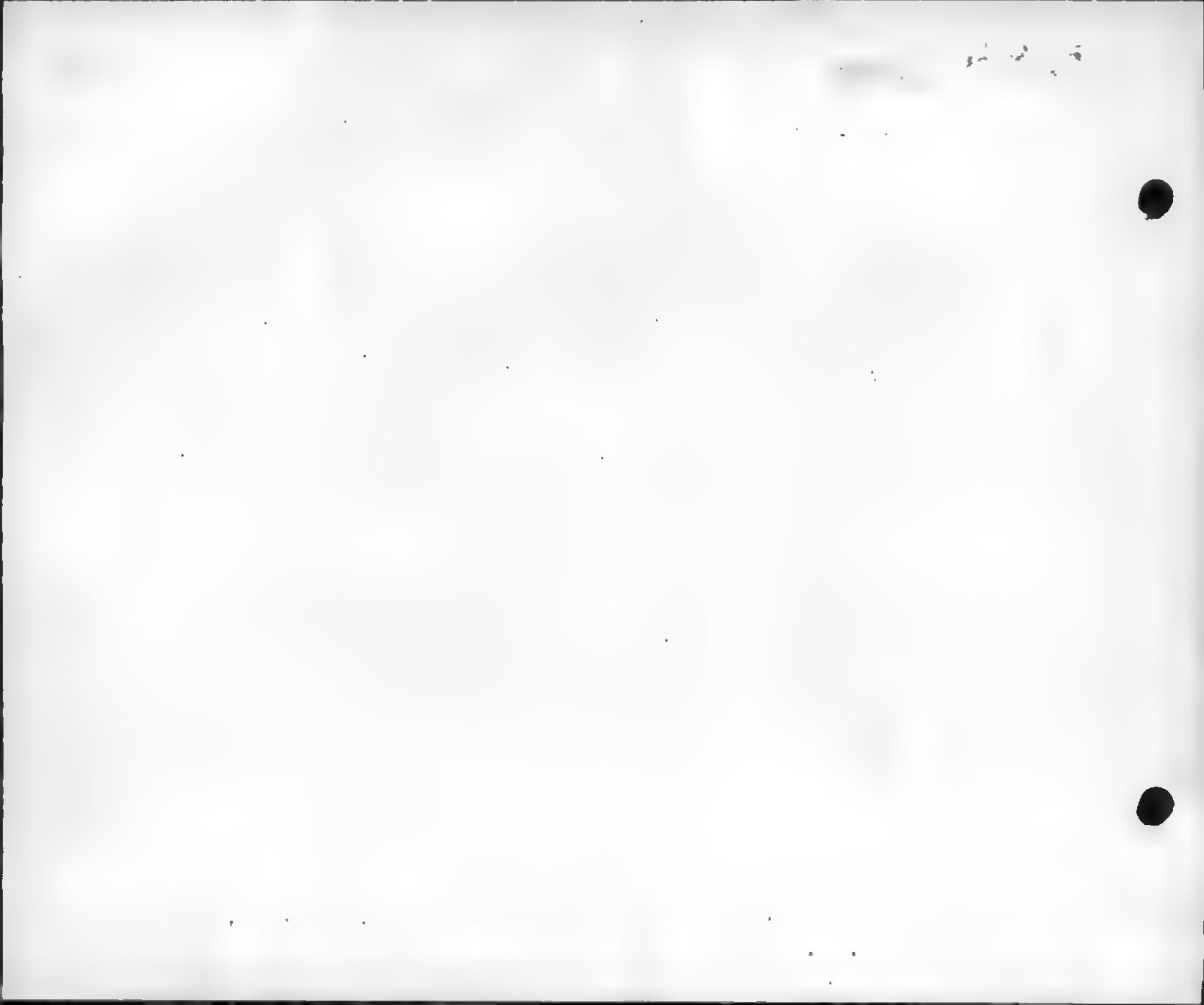
FOR STATE  
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02027

1 PLACE OF DEATH a. CO. NTY <u>Balto.</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Balto.</u>		c. LENGTH OF STAY in 1b <u>3 1/2 yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1514 E. Lombard St.</u>		d. STREET ADDRESS <u>Same.</u>	
3 NAME OF DECEASED (Type or print) <u>RAYMOND J. THALHEIMER</u>		4 DATE OF DEATH Month <u>Feb</u> Day <u>7</u> Year <u>1966</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W. DOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Jan 26, 1893</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Singer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Entertainment</u>	
11 BIRTHPLACE (State or foreign country) <u>Balto.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>J. Lewis Thalheimer</u>		14 MOTHER'S MAIDEN NAME <u>Katherine Minnick</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service) <u>No</u>		16 SOCIAL SECURITY NO. <u>216369999</u>	
17 INFORMANT <u>Eugene L. Thalheimer (Same)</u>		Address <u>Same</u>	
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Artery Disease</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>None</u> (c) <u>None</u>			INTERVAL BETWEEN ONSET AND DEATH <u>None</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>None</u>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>2:00</u> p.m. <u>None</u>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>
20f. (City or town) <u>Balto.</u> (County) <u>Md.</u> (State) <u>Md.</u>		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <u>D. D. Caples</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>D. D. CAPLES</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <u>2-7-66</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town or county) <u>None</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	
23b. DATE THEREOF <u>2/11/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>	
23d. LOCATION (City or Town) <u>Balto.</u> (County) <u>Md.</u> (State) <u>Md.</u>		23e. LOCATION (City or Town) <u>Balto.</u> (County) <u>Md.</u> (State) <u>Md.</u>	
24. FUNERAL DIRECTOR <u>Witzke F. D. 4101 Edmondson Ave</u>		25a. REC'D BY REGISTRAR <u>FEB 8 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 7-62

02081

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02028

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Timonium</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Chesapeake Manor Nursing Home</b>		d. STREET ADDRESS <b>309 Lochview Terrace</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Alice Matilda Thomas</b>		4. DATE OF DEATH Month Day Year <b>Feb. 3 19 66</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 16, 1876,</b>
9. AGE (In years last birthday) <b>89</b> yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Vice-President</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Acme Steel</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Knox Peregoy</b>		14. MOTHER'S MAIDEN NAME <b>Maria Adams</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>219-16-4724</b>	
17. INFORMANT <b>Charles W. Thomas</b>		Address <b>309 Lochview Terrace</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic myocarditis</b> DUE TO (b) <b>Arteriosclerotic hypertensive C-V disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Associated nephrosclerosis (terminal uremia)</b>		INTERVAL BETWEEN ONSET AND DEATH <b>18 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18) <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>		20f. (City or town) (County) (State) <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <b>June 28, 1954</b> to <b>Feb. 3, 1966</b> that (I) last saw the deceased alive on <b>Feb. 1, 1966</b> , and that death occurred at <b>2 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>H.V. Harbold</b>		22b. DATE SIGNED <b>Feb. 4 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>H.V. HARBOLD M.D.</b>		22d. ADDRESS <b>4706 Harford Road Baltimore Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Entombment</b>		23b. DATE THEREOF <b>Feb. 7, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Mausoleum</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook-Brooks Towson</b>		24. ADDRESS <b>1050 York Rd.</b>	
25a. REC'D BY REGISTRAR <b>Feb 8 1966</b>		25b. REGISTRAR'S SIGNATURE <b>John</b>	

10. 10

10. 10

1. 10

10. 10

1. 10

1. 10

1. 10

1. 10

1. 10

1. 10

1. 10

1. 10

1. 10

1. 10

1. 10

1. 10

1. 10

1. 10

1. 10

1. 10

1. 10

1. 10

1. 10

1. 10

1. 10

1. 10

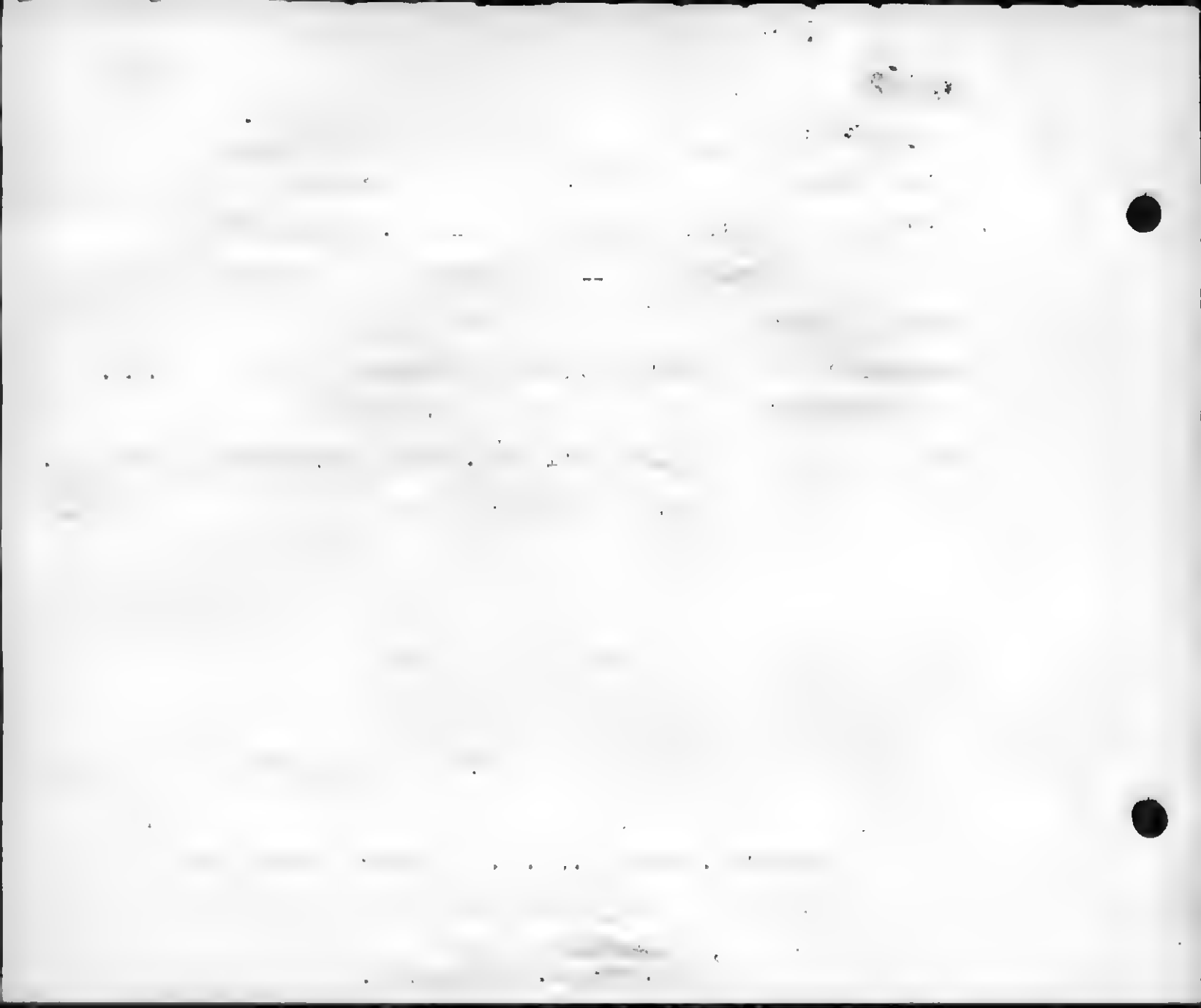
1. 10

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>BALTIMORE</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b> c. LENGTH OF STAY IN 1b <b>76 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> "b. COUNTY" c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> d. STREET ADDRESS <b>1431 N. FREMONT AVENUE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>EDWARD -- THOMPSON</b> <b>5. SEX</b> <b>MALE</b> <b>6. COLOR OR RACE</b> <b>NEGRO</b> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <b>MAY 2, 1898</b> <b>9. AGE</b> (In years last birthday) <b>67</b> yrs. IF UNDER 1 YEAR: Months Days Hours Min. <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>TRUCK DRIVER</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>TRUCKING COMPANY</b> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>REISTERSTOWN, MARYLAND</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b> <b>13. FATHER'S NAME</b> <b>ALLAN THOMPSON</b> <b>14. MOTHER'S MAIDEN NAME</b> <b>ELLA SIMMS</b> <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW I</b> <b>16. SOCIAL SECURITY NO.</b> <b>218 05 2491</b> <b>17. INFORMANT</b> <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b> Address		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <b>METASTATIC CARCINOMA OF LUNG</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>		<b>21. I certify that (X) (this hospital) attended the deceased from 12/9/65, 19 to 2/23/66, 19, that (X) (we) last saw the deceased alive on 2/23/66, 19, and that death occurred at 3:05 PM, from the causes and on the date stated above.</b> <b>22a. SIGNATURE</b> <i>Lawrence F. Awalt, Jr.</i> M.D. <b>22b. DATE SIGNED</b> <b>2/23/66</b> <b>22c. PHYSICIAN'S NAME (Type)</b> <b>LAWRENCE F. AWALT, JR., M. D.</b> <b>22d. ADDRESS</b> <b>VAH FORT HOWARD, MARYLAND</b>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>BURIAL</b> <b>23b. DATE THEREOF</b> <b>Feb. 28, 1966</b> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>BALTIMORE NATIONAL</b> <b>23d. LOCATION (City, town or county) (State)</b> <b>BALTIMORE, MARYLAND</b> <b>24. FUNERAL DIRECTOR</b> <b>A dolphus Halstead, Funeral Home</b> <b>1206 W. NORTH AVE. BALTIMORE, MD.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>FEB 28 1966</b> <b>25b. REGISTRAR'S SIGNATURE</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if any want, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the **final** certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
20M 1/65

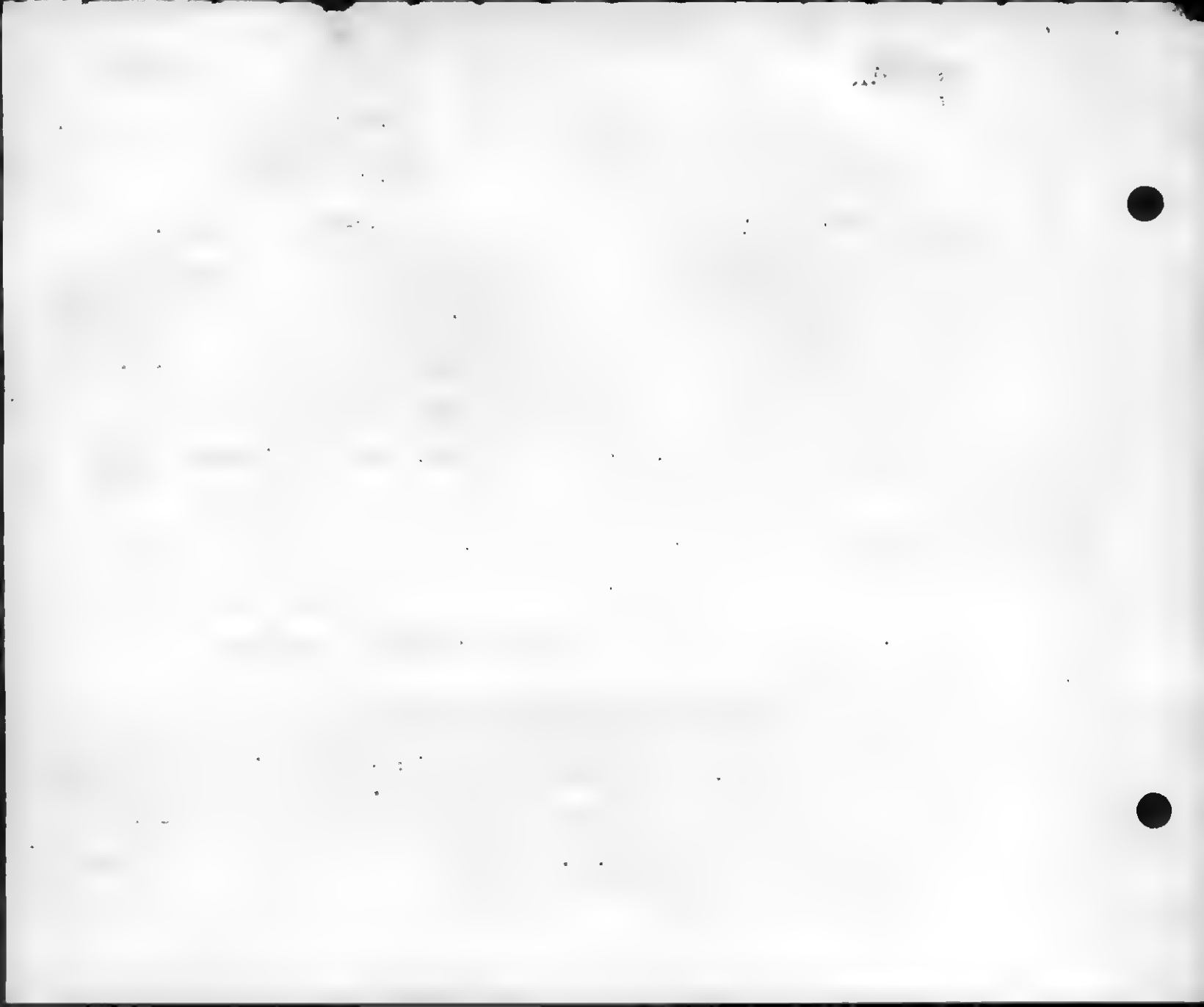
**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

02083

02030

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <span style="float: right;">MARYLAND</span>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN ID <b>10yrs 10mth 20dys</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis, Maryland</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>				d. STREET ADDRESS <b>Agahart-Annapolis Roads</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Thomas Thrift</b>			4. DATE OF DEATH <b>February 3 1966</b>				
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 1, 1884</b>		9. AGE (In years last birthday) <b>81 yrs.</b>		IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>James</b>			14. MOTHER'S MAIDEN NAME <b>Nana</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>216-18-5459</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular accident</b> <b>4700</b> OUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> OUE TO (c) <b>Generalized arteriosclerosis</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic brain syndrome associated with circulatory disturbance</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>March 11, 1955</b> , to <b>Feb. 3, 1966</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Feb. 3, 1966</b> , and that death occurred at <b>9:45 P.</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Stella Wachslar</b>			22b. DATE SIGNED <b>2-4-66</b>				
22c. PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>			22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>Mar. 2, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. John's A. S. C. School</b>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR <b>Spring Grove State Hosp.</b>			25a. REC'D BY REGISTRAR <b>FEB 10 1966</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

MEDICAL CERTIFICATION



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

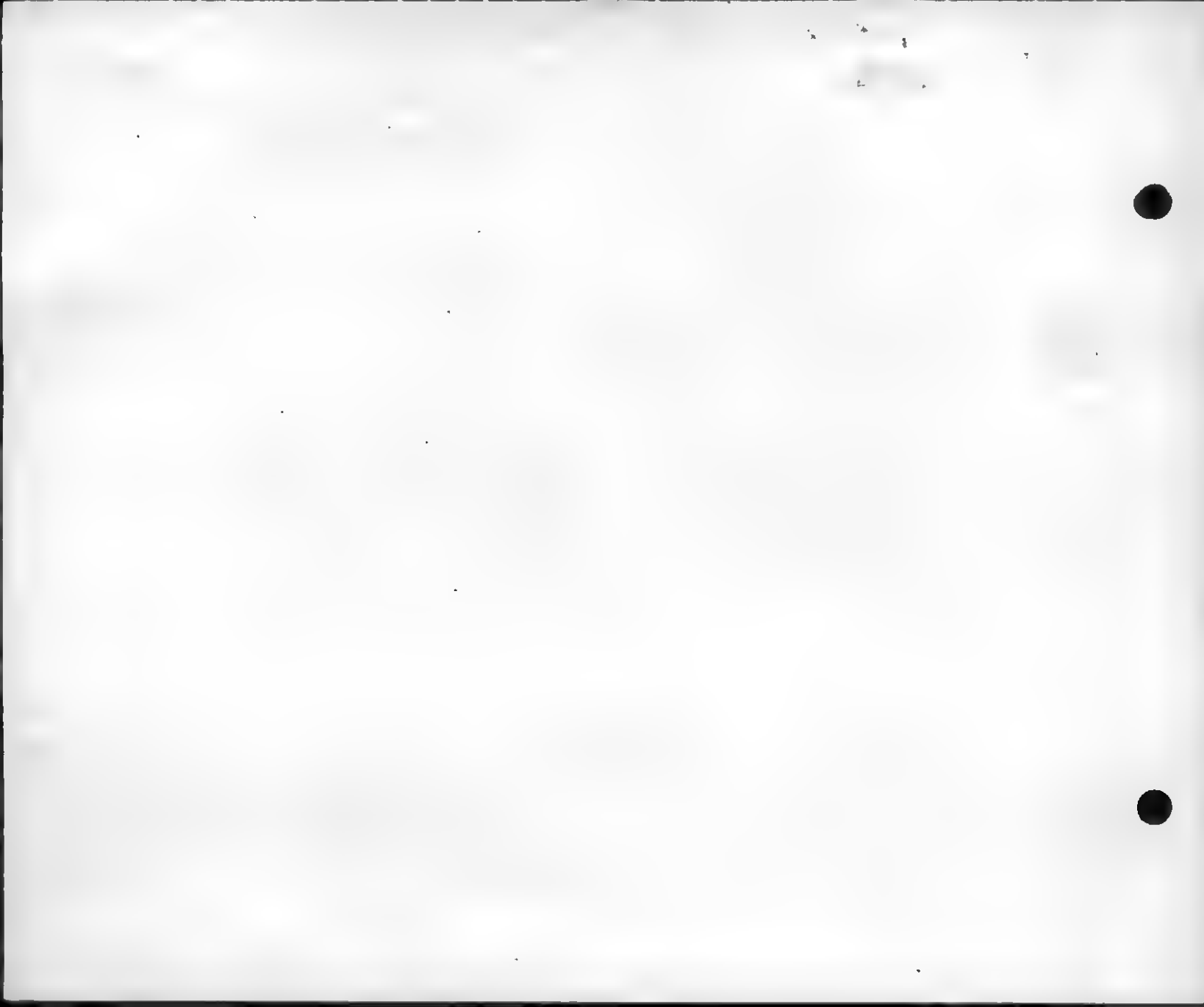
02084

02031

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bessef</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bessef</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>31 Arenal Rd.</u>		d. STREET ADDRESS <u>31 Arenal Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Anna Mae</u> Middle <u>Pobias</u> Last <u>Pobias</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>10</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 10, 1925</u>
9. AGE (In years lost birthday) <u>40</u> yrs		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>H. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Ray Hartman</u>		14. MOTHER'S MAIDEN NAME <u>Grace Simon</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>210-12-5267</u>	
17. INFORMANT <u>Husband (Same as above)</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Pneumonia</u> DUE TO (c) <u>Generalized arteriosclerosis - with my heart - atherosclerosis - atherosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>3 days</u> <u>several yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>8</u> , 19 <u>65</u> , to <u>2/10</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2/9</u> 19 <u>66</u> , and that death occurred at <u>8:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>J. Platt M.D.</u>		22b. DATE SIGNED <u>2/12/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. PLATT M.D.</u>		22d. ADDRESS <u>406 EASTERN BLVD. ESSEX, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2/14/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Belair Memorial</u>	23d. LOCATION (City or Town) (County) (State) <u>Balto Md.</u>
24. FUNERAL DIRECTOR <u>Cornelley 300 Mace Ave. Balto. 21</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>FEB 15 1966</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please file the above carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

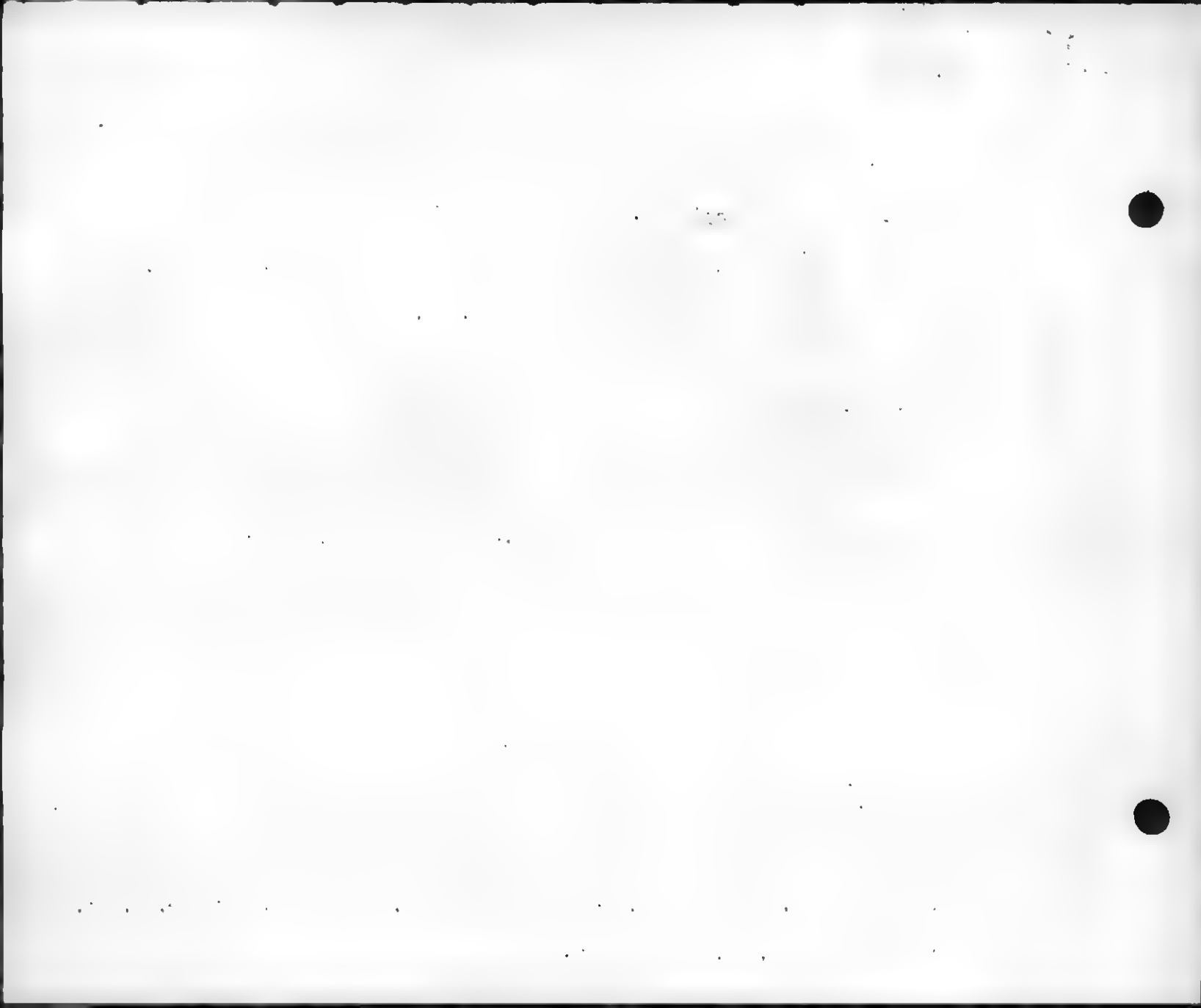
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02085

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02032

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>		c. LENGTH OF STAY IN 1b <i>Towson</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>		d. STREET ADDRESS <i>542 Park Avenue</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Ethel Isenrock Trapp</i>		4. DATE OF DEATH Month <i>February</i> Day <i>20</i> Year <i>1966</i>		5. SEX <i>Female</i>		6. COLOR OF RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Feb. 23, 1892</i>		9. AGE (in years last birthday) <i>73</i> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Charles Isenrock</i>		14. MOTHER'S MAIDEN NAME <i>Francis</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes give war or dates of service) <i>None</i>	
16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Family records</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>METASTATIC CARCINOMA</i> DUE TO (b) <i>CARCINOMA HEAD OF PANCREAS</i> DUE TO (c) <i></i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <i>2 mos 4 ps</i>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i></i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) <del>(the hospital)</del> attended the deceased from <i>FEB 12, 1966</i> to <i>FEB 20, 1966</i> , that (I) <del>(we)</del> last saw the deceased alive on <i>FEB 20, 1966</i> , and that death occurred at <i>8:20 P.M.</i> from the causes and on the date stated above.		22a. SIGNATURE <i>T.C. Siwinski</i>		22b. DATE SIGNED <i>FEB 23, 1966</i>	
22c. PHYSICIAN'S NAME (Type) <i>T.C. SIWINSKI</i>		22d. ADDRESS <i>206 W PENNA. AV. TOWSON MD</i>		23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Feb. 23, 1966</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. John's Lutheran Cem.</i>		23d. LOCATION (City, town or county) (State) <i>Blenheim, Balto. Co., Md.</i>		24. FUNERAL DIRECTOR <i>John Burns' Sons, Towson, Maryland</i>	
25a. REC'D BY REGISTRAR <i>MAR 2 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>											



1  
7

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02086		MARYLAND STATE DEPARTMENT OF HEALTH		02033	
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND					
Item 8 per Telephone		CERTIFICATE OF DEATH			
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baltimore County Gen. Hosp.</u>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>4005 Oakford Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Richard</u> Middle <u>Sucker</u> Last <u>Sucker</u>			4. DATE OF DEATH Month <u>Feb.</u> Day <u>15</u> Year <u>1966</u>		
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Librarian</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sec. Co.</u>		9. AGE (in years last birthday) <u>57</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>5</u> Days <u>7</u> Hours <u>15</u> Min. <u>00</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Argentina</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Jack Sucker</u>			14. MOTHER'S MAIDEN NAME <u>Isabelle Tucker</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>76</u>		17. INFORMANT <u>MRS. ISABELLE TUCKER 4005 OAKFORD AVENUE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> <u>4201</u> DUE TO (b) <u>Coronary Insufficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Coronary Insufficiency</u>					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 14</u> , 19 <u>66</u> to <u>Feb. 15</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>Feb. 15</u> , 19 <u>66</u> , and that death occurred at <u>9:15</u> M. from the causes and on the date stated above.					
22a. SIGNATURE <u>L. B. Lerma</u>			22b. DATE SIGNED <u>2-15-66</u>		
22c. PHYSICIAN'S NAME (Type) <u>L. B. Lerma</u>			22d. ADDRESS <u>Balt. County Gen. Hosp.</u>		
23a. BURIAL, CREMATION, REBURYAL (Specify)		23b. DATE THEREOF <u>2/16/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CHEVRA AHAVAS CHESED INC.</u>	
23d. LOCATION (City, town or county)		23e. (State) <u>RANDALLSTOWN, MARYLAND</u>			
24. FUNERAL DIRECTOR <u>St. Kermon + Bros. Inc.</u>			25a. REC'D BY REGISTRAR <u>FEB 17 1966</u>		
25b. REGISTRAR'S SIGNATURE <u>John J. Judge</u>			25c. REGISTRAR'S ADDRESS <u>6010 REGISTERSTOWN ROAD</u>		

Page 10

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

415 (4)  
1/65

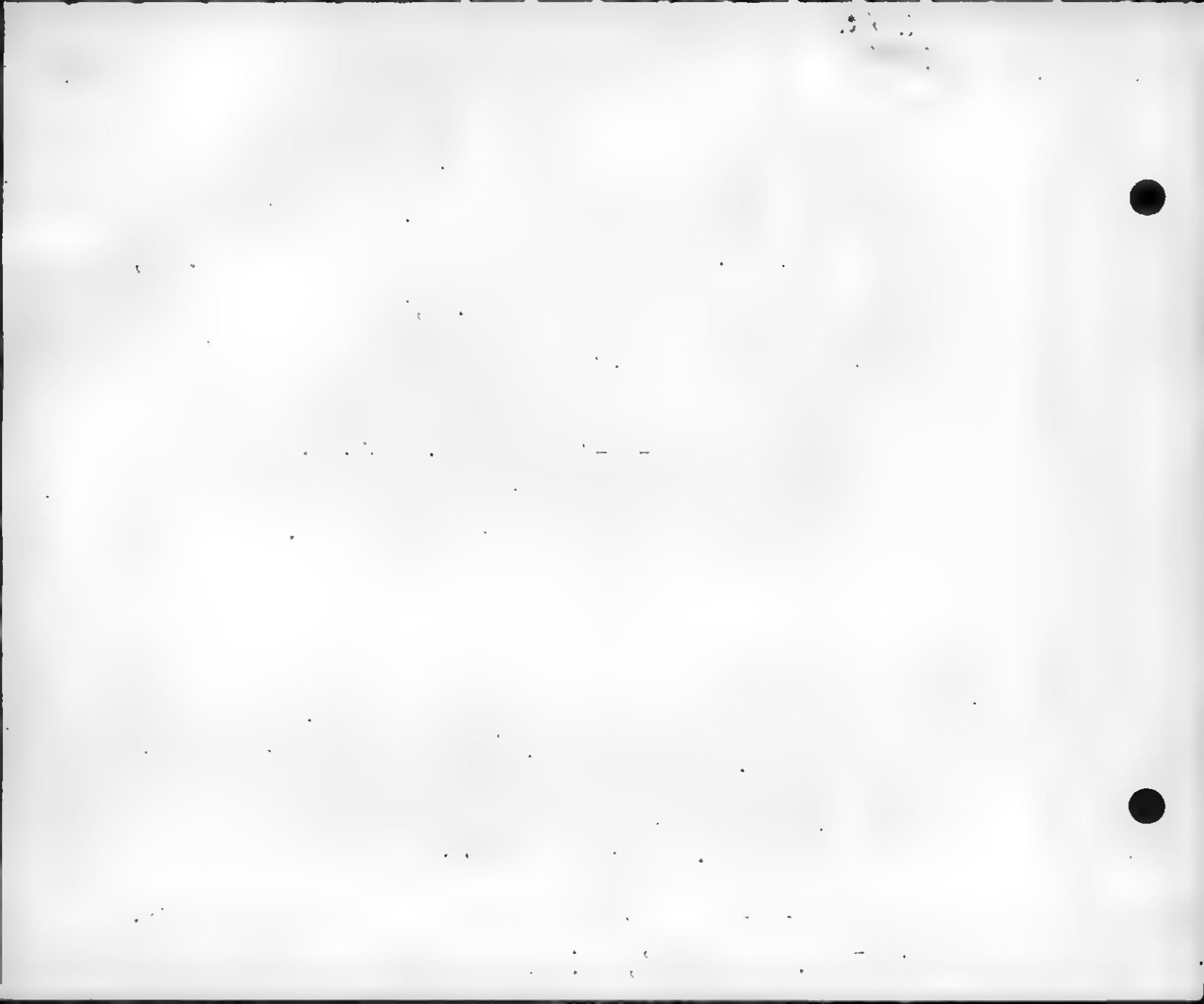
MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
02087					02034				
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Caton, Md					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) North East, Maryland				
c. LENGTH OF STAY IN 1b 2yrlnth2dys					d. STREET ADDRESS R.F.D. #1				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Gertrude			First Middle Last Ushaf r		4. DATE OF DEATH February 25 1966		Month Day Year		
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH unknown		9. AGE (In years last birthday) 85? yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME unknown				14. MOTHER'S MAIDEN NAME unknown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unknown				16. SOCIAL SECURITY NO. 526-04-8252		17. INFORMANT Records: SPRING GROVE STATE HOS AL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEART FAILURE 4500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROSIS DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (if this hospital) attended the deceased from Dec. 12, 1963, to Feb-25, 1966, that (I) (we) last saw the deceased alive on 19, and that death occurred at 4 PM, from the causes and on the date stated above.									
22a. SIGNATURE Ricardo Ibanez				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 9-26-66			
22c. PHYSICIAN'S NAME (Type) RICARDO IBANEZ				22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/1/66		23c. NAME OF CEMETERY OR CREMATORY Charlestown Cemetery		23d. LOCATION (City, town or county) (State) Charlestown, Md.			
24. FUNERAL DIRECTOR Grant Funeral Home				ADDRESS Box 22 North East, Md.		25a. REC'D BY REGISTRAR MAR 1 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

X

February 52 66

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
02088 CERTIFICATE OF DEATH 02035												
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Towson</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Chesapeake Manor Nursing Home</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>8705 Raven Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <b>Earl R. Van Sickle</b>			First Middle Last			4. DATE OF DEATH <b>Feb. 26, 1966</b>			Month Day Year			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 9, 1871</b>		9. AGE (in years last birthday) <b>87 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Self Employed</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Tailor</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Indiana</b>			12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>Unknown</b>						14. MOTHER'S MAIDEN NAME <b>Unknown</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>060-28-7450</b>		17. INFORMANT <b>A Mrs. Laura B. VanSickle</b>			Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>131X</b> DUE TO <b>Pagst disease of the bones (Osteitis deformans)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH <b>Over year</b>												
MEDICAL CERTIFICATION												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <b>March 1, 1965</b> to <b>February 26, 1966</b> , that (I) (we) last saw the deceased alive on <b>February 25, 1966</b> , and that death occurred at <b>12:30 AM</b> , from the causes and on the date stated above.												
22a. SIGNATURE <b>W. G. Helfrich</b>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>William G. Helfrich</b>						22d. ADDRESS <b>5206 Roland Ave</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>			23b. DATE THEREOF <b>2-28-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Green Mount</b>			23d. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>				
24. FUNERAL DIRECTOR <b>Mitchell-Wiedefeld Home, Inc.</b> <b>6500 York Rd. Baltimore, Md. 21212</b>						25a. REC'D BY REGISTRAR <b>MAR 1 1966</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

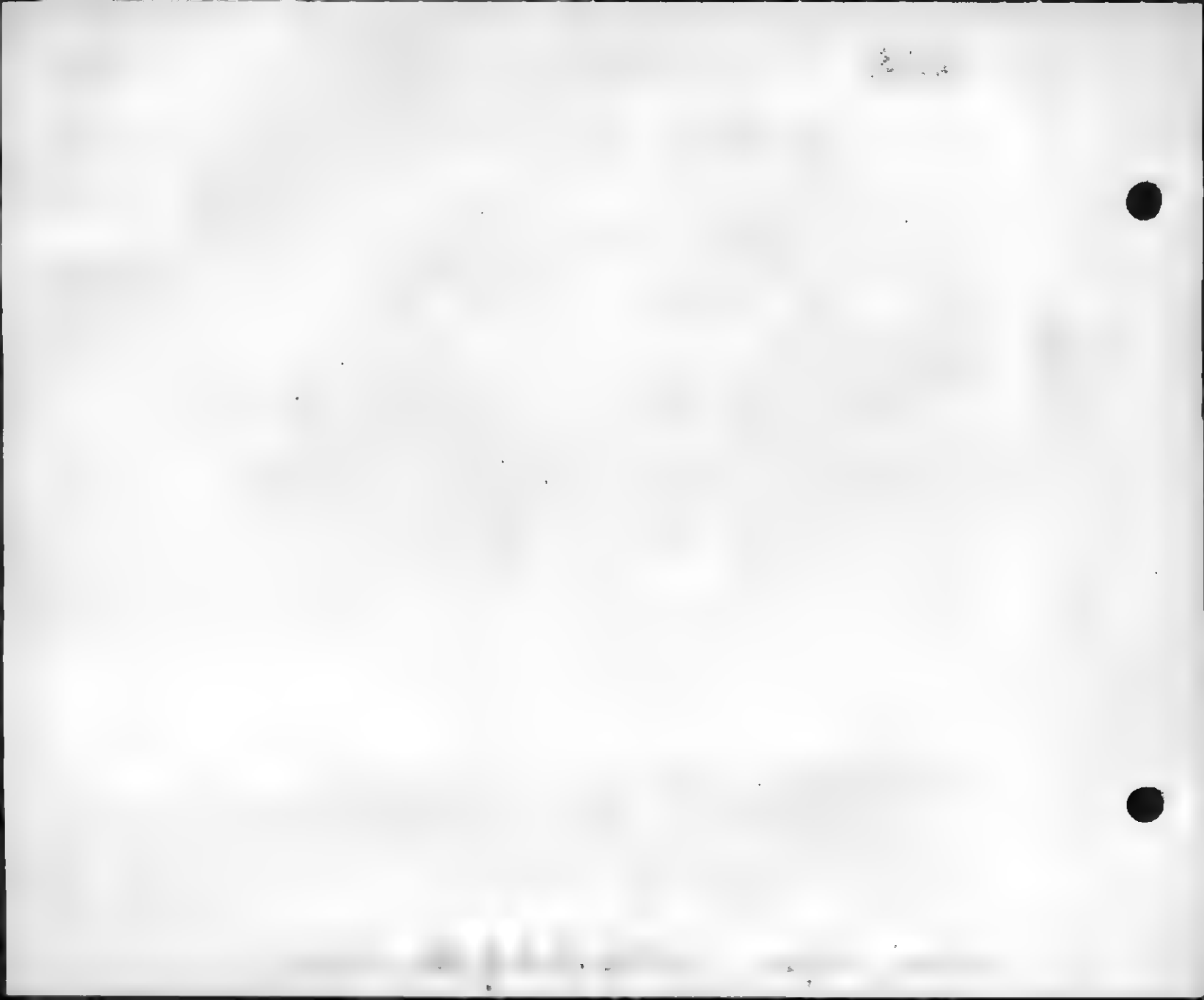


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then page 4 should be removed from the certificate and removed from any event, within 72 hours after death should be filed with the State Dept. of Health prior to burial, cremation, or removal.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02089		ITEM 236-111m						02036			
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Pa.</u> b. COUNTY <u>Fayette</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>				c. LENGTH OF STAY IN 15 <u>4 wks.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hibbs, Pa.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Balto Co. General Hospital</u>				d. STREET ADDRESS <u>5403 LEWELLEN AVE</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>—</u> (Varvak) Last <u>VAVRECK</u>				4. DATE OF DEATH Month <u>2</u> Day <u>22</u> Year <u>1966</u>							
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1892</u>		9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <u>EUROPE Austria Hungary U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>STEVE PACAK</u>				14. MOTHER'S MAIDEN NAME <u>SOPHIA HART-GEY</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>				17. INFORMANT Address <u>Elizabeth Bukoszar 5403 Lewellen Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> <u>157X</u> DUE TO (b) <u>Cerebral Jaundice</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Carcinoma Pancreas</u>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>JAN. 27, 1966</u> to <u>FEB. 22, 1966</u> , that (I) (we) last saw the deceased alive on <u>FEB 22 1966</u> and that death occurred at <u>8:12 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Antonio R. Jara</u>								22b. DATE SIGNED <u>2-22-66</u>			
22c. PHYSICIAN'S NAME (Type) <u>—</u>								22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>2-22-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New Salem Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>New Salem, Pa.</u>			
24. FUNERAL DIRECTOR <u>Loring Byers</u>				ADDRESS <u>8728 Liberty Rd</u>		25a. REC'D BY REGISTRAR <u>—</u>		25b. REGISTRAR'S SIGNATURE <u>John L. Judge</u>			
DATE <u>FEB 23 1966</u>											

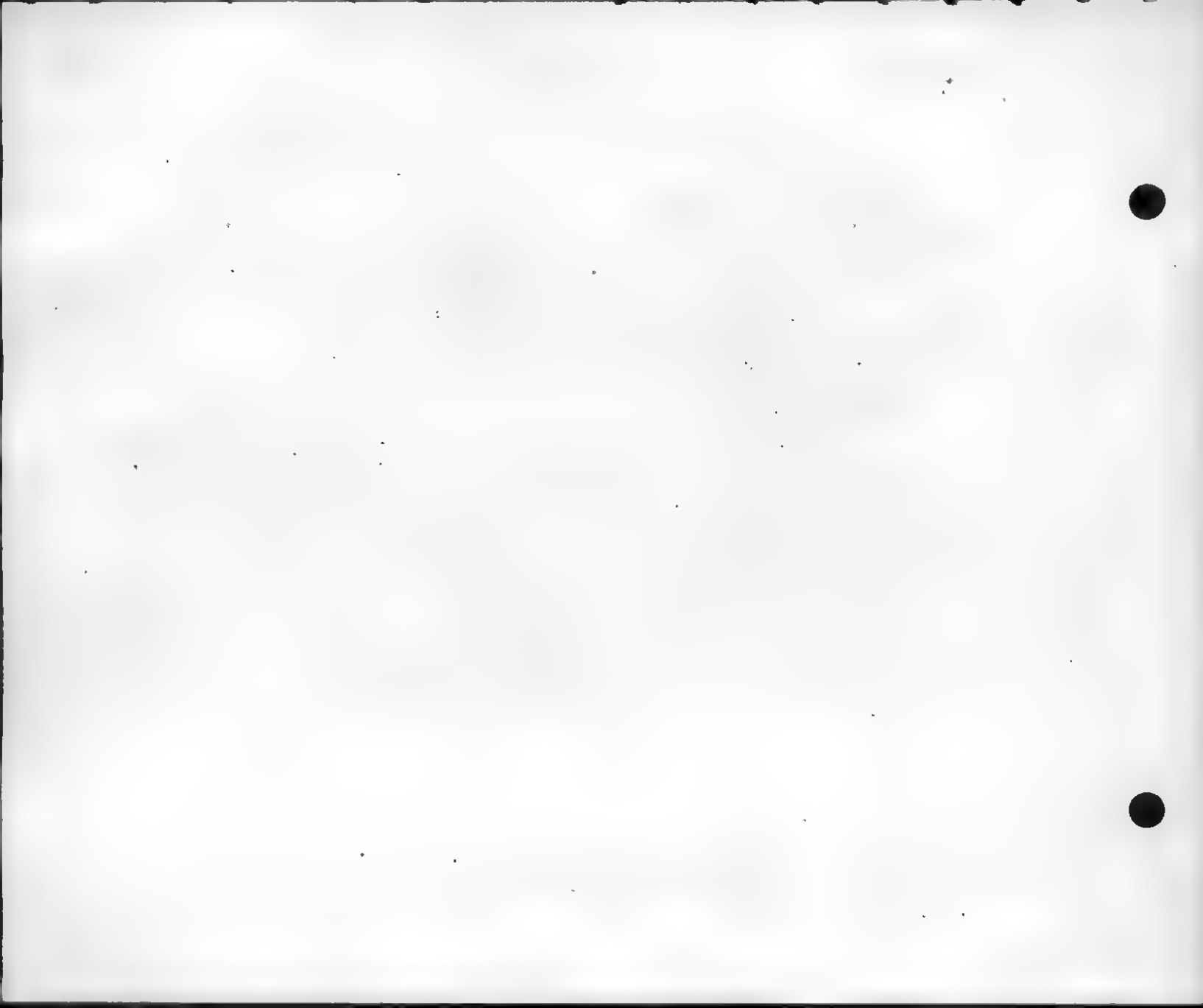


TO HOSPITAL OR ATTENDING PHYSICIAN: The **1** requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <span style="float: right;">MARYLAND</span>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>✓</u></span>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 21206</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>St. Joseph Hospital</u>						d. STREET ADDRESS <u>2130 S. Boundary Ave.</u>					
3. NAME OF DECEASED (Type or print) <u>Leon C. Warren</u>			First Middle Last			4. DATE OF DEATH <u>February 25 19 66</u>			Month Day Year		
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/28/08</u>		9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Stationary Engineer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Iron Can</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Edward North Carolina</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Clarence H. Warren</u>						14. MOTHER'S MAIDEN NAME <u>Nancy M. Lewis</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>212-09-5076</u>		17. INFORMANT Address <u>Mrs. Nora L. Warren 21206</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>2201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 22</u> , 19 <u>66</u> , to <u>Feb. 25</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Feb. 25</u> 19 <u>66</u> , and that death occurred at <u>2:50</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>H. C. Yoon</u>						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>Feb. 25 1966</u>			
22c. PHYSICIAN'S NAME (Type) <u>H.C. Yoon</u>						22d. ADDRESS <u>7620 York Rd. Baltimore, Md. 21204</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/1/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>First Evangelical Church</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore Md.</u>					
24. FUNERAL DIRECTOR <u>HENRY SANDER &amp; SONS INC. BALTO. MD</u>						25a. REC'D BY REGISTRAR <u>FEB 23 1966</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

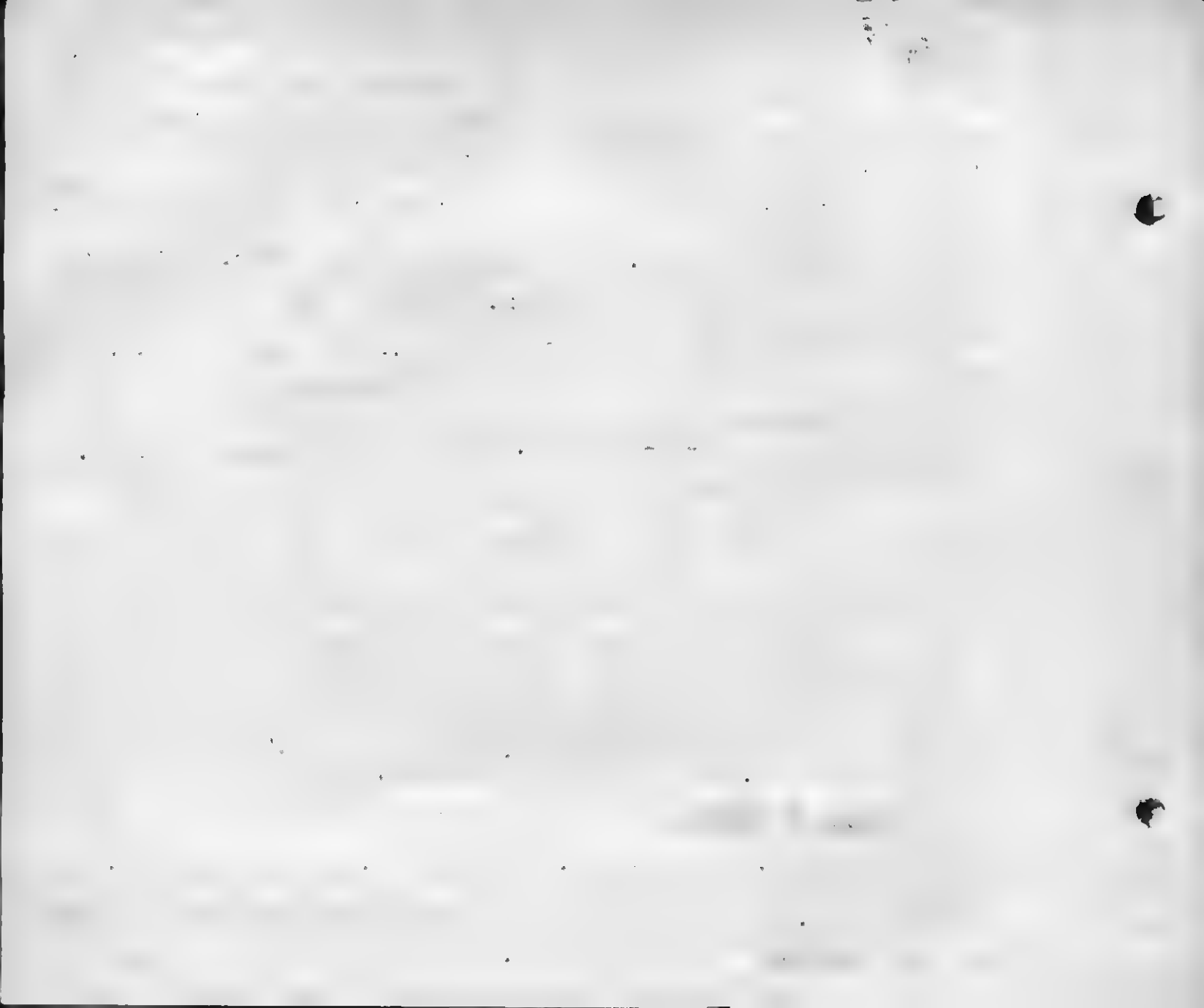
02091

## CERTIFICATE OF DEATH

02038

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b> c. LENGTH OF STAY IN b <b>33 years</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>403 Dyer Avenue</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Reisterstown</b> d. STREET ADDRESS <b>403 Dyer Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Frank O. Watts</b>	4. DATE OF DEATH <b>Feb. 7 1966</b>	5. SEX <b>Male</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <b>Mar. 15, 1896</b> 9. AGE (In years last birthday) <b>69</b> yrs. IF UNDER 1 YEAR: Months <b>69</b> Days <b>69</b> IF UNDER 24 HRS. Hours <b>69</b> Min. <b>69</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Barber</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self-employed Cecil Co., Kentucky</b>	
13. FATHER'S NAME <b>Mose Watts</b>		14. MOTHER'S MAIDEN NAME <b>Alice Souers</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes give war or dates of service) <b>WWI</b>		16. SOCIAL SECURITY NO. <b>218-32-5345</b>	
17. INFORMANT <b>Mrs. Louise Watts</b>		Address <b>403 Dyer Avenue, Reisterstown, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>177X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Carcinoma Prostate</b> (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>2 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Feb. 13, 1957</b> to <b>Feb. 7, 1966</b> that (I) (we) last saw the deceased alive on <b>Feb. 6, 1966</b> and that death occurred at <b>1 A.M.</b> from the causes and on the date stated above			
22a. SIGNATURE <b>Martin E. Strobel</b>		22b. DATE SIGNED <b>2-8-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Martin E. Strobel, M.D.</b>		22d. ADDRESS <b>48 Main St., Reisterstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Feb. 10, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>All Saints Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Reisterstown Maryland</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Henry James Eckhardt</b>		25a. REC'D BY REGISTRAR <b>Feb 9 1966</b> 25b. REGISTRAR'S SIGNATURE <b>J. A. Jones</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4 may be retained by the hospital or attending physician, and completely filled in by the funeral director. After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please return the certificate papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
20M 5-63

M

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
02092											
1. PLACE OF DEATH a. COUNTY <u>Balto</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>✓</u>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Balto</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Shangri-La Nursing Home</u>				d. STREET ADDRESS <u>5014 Edmonds</u>							
3. NAME OF DECEASED (Type or print) <u>George W. Webb</u>				4. DATE OF DEATH <u>Feb. 18/66</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Apr 3/84</u>		9. AGE (in years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR: Months <u>1</u> Days <u>18</u> Hours <u>18</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <u>Balto Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Geo. G.</u>				14. MOTHER'S MAIDEN NAME <u>Katherine</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.				17. INFORMANT <u>Mrs. Helen Webb</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>arteriosclerosis C.V.D.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a); 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1962</u> to <u>Feb 18, 1966</u> , that (I) (we) last saw the deceased alive on <u>Feb 18, 1966</u> , and that death occurred at <u>8 P.M.</u> from the causes and on the date stated above											
22a. SIGNATURE <u>J. C. Pouro</u> M.D.				22b. DATE SIGNED <u>2/21/66</u>							
22c. PHYSICIAN'S NAME (Type) <u>J. C. Pouro</u>				22d. ADDRESS <u>3325 Frederick Ave</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>				23b. DATE THEREOF <u>2/22/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood</u>		23d. LOCATION (City, town or county) (State) <u>Balto. Md</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Witke T. H.</u>				ADDRESS <u>4101 Edmonds</u>				25. REC'D BY REGISTRAR <u>Feb 21 1966</u>		25a. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION

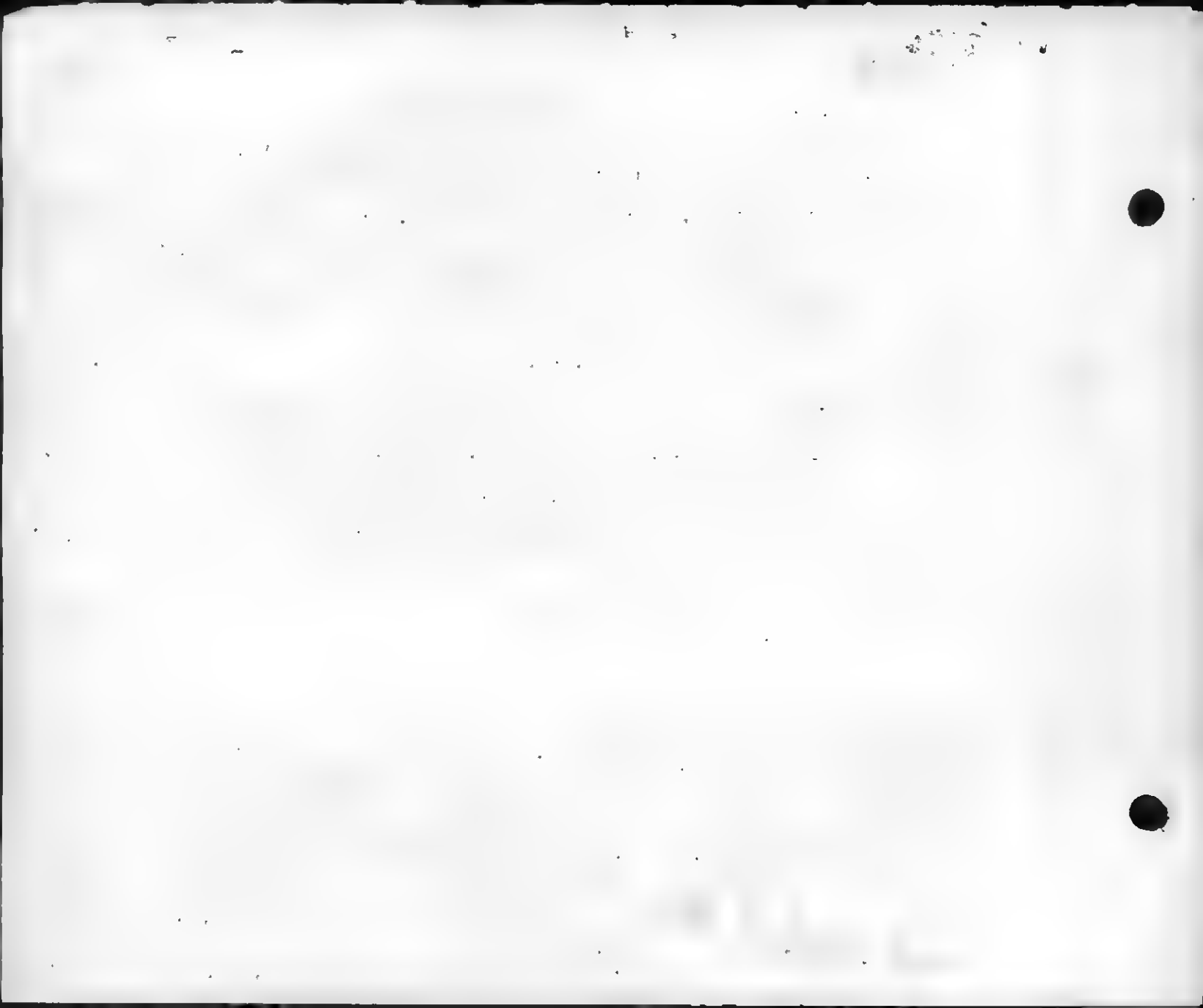


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
02093					02040				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY <b>BALTIMORE</b>					a. STATE <b>MARYLAND</b> b. COUNTY <b>MD</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>				
c. LENGTH OF STAY IN 1b <b>7 DAYS</b>					d. STREET ADDRESS <b>949 N. GAY STREET</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>SAMUEL</b>			First Middle Last <b>-- WEBSTER</b>			4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>1</b> Year <b>19 66</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>NEGRO</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12/3/92</b>		9. AGE (In years last birthday) <b>73</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CHAUFFEUR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CHAIR MFG. CO.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>FLORIDA</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>SAMUEL WEBSTER</b>					14. MOTHER'S MAIDEN NAME <b>GEORGIA MN: UNKNOWN</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>WW I 219-01-4790</b>		17. INFORMANT <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PASSIVE CONGESTION OF THE HEART</b> DUE TO (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO (c) <b>UNKNOWN</b>					INTERVAL BETWEEN ONSET AND DEATH <b>5 WEEKS</b>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CHRONIC PULMONARY EMPHYSEMA</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (he/she) attended the deceased from <b>1/25/66</b> , 19 <b>66</b> to <b>2/1/66</b> , 19 <b>66</b> , that (he) (we) last saw the deceased alive on <b>2/1/66</b> , 19 <b>66</b> , and that death occurred at <b>12:45p</b> M. from the causes and on the date stated above.									
22a. SIGNATURE <b>Peter V. Juvan</b>					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>2/2/66</b>		
22c. PHYSICIAN'S NAME (Type) <b>PETER V. JUVAN, M. D.</b>					22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE THEREOF <b>2-7-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>		23d. LOCATION (City, town or county) (State) <b>BALTIMORE, MD</b>		
24. FUNERAL DIRECTOR <b>JOSEPH KNIGHT</b>					25a. REC'D BY REGISTRAR <b>Feb 4 1966</b> 25b. REGISTRAR'S SIGNATURE <b>KNIGHT FUNERAL HOME</b> <b>BROADWAY &amp; LANVALE STS. BALTIMORE, MD.</b>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4, may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

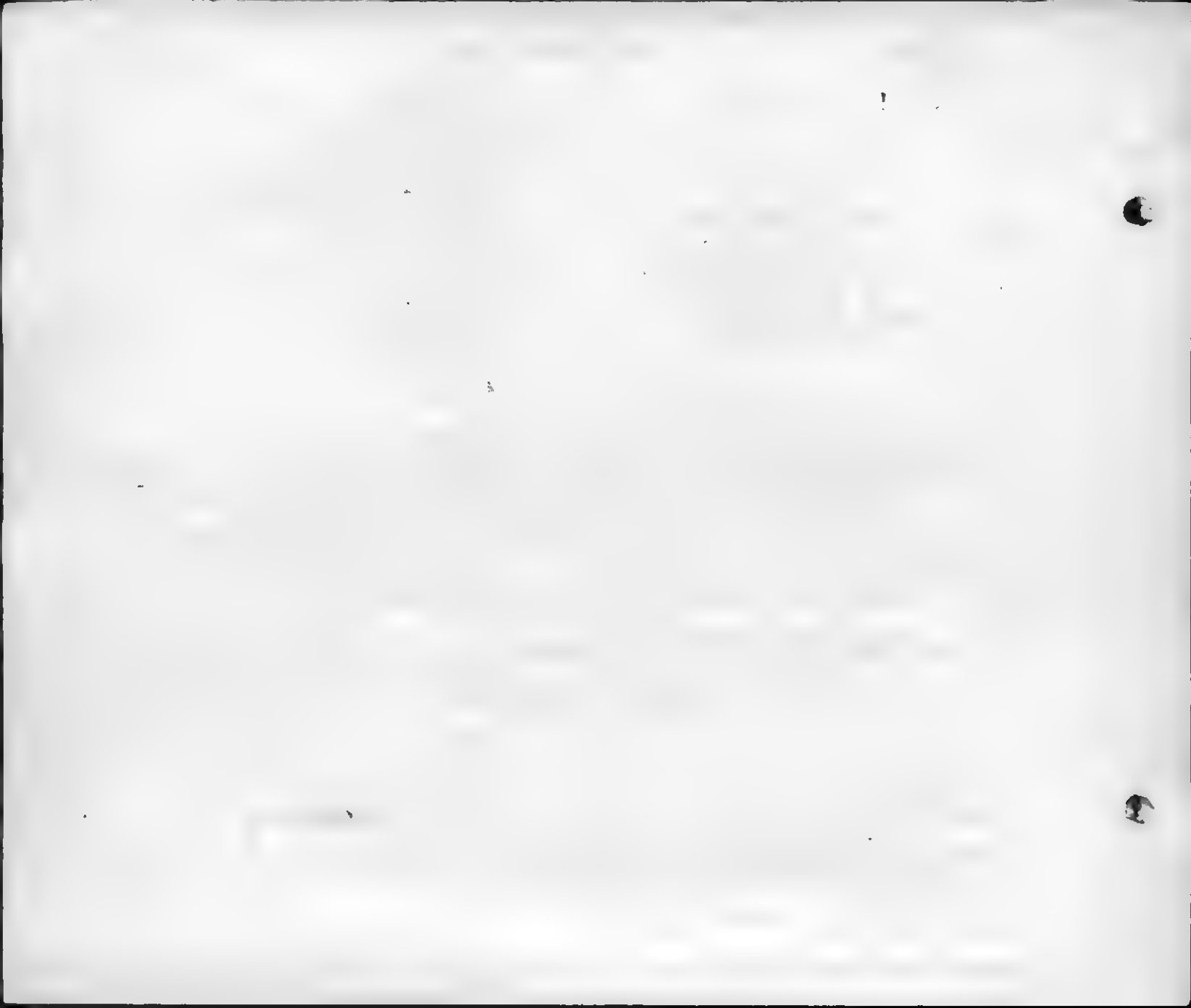
## CERTIFICATE OF DEATH

Reg. Dist. No.

02094

02041

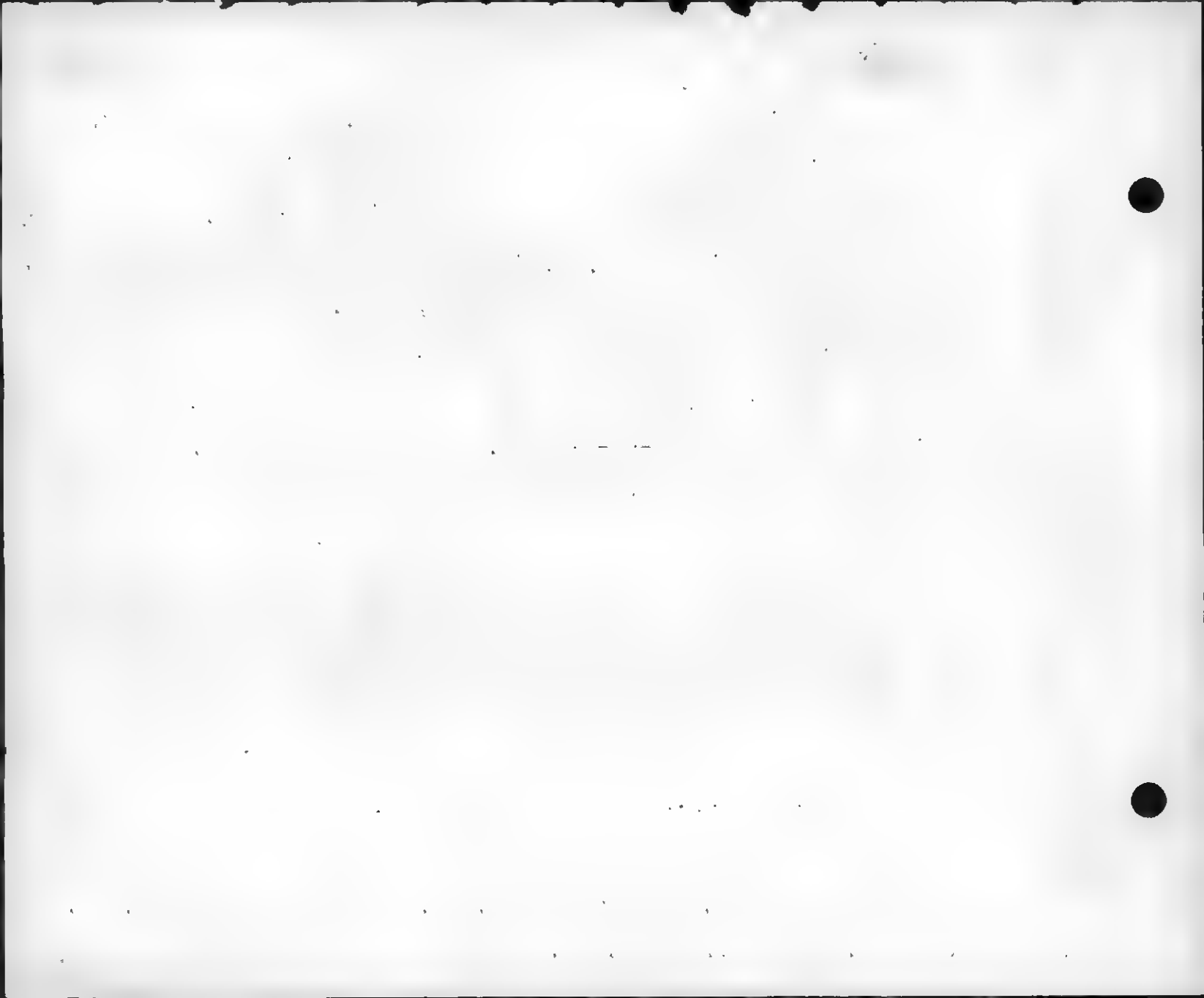
1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>				c. LENGTH OF STAY IN 1b <b>1 YR.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>30 N SYMINGTON AVE</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>DANIEL JOHNSON WHITCHURCH</b>				4. DATE OF DEATH Month Day Year <b>FEB 17 1966</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1894 JULY 20, 1893</b>	
9. AGE (In years lost birthday) yrs. <b>72</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WELDER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>STEEL MFG.</b>		11. BIRTHPLACE (State or foreign country) <b>WEST PITTSBURGH, PA.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>ARTHUR WHITCHURCH</b>			
14. MOTHER'S MAIDEN NAME <b>MARIAH JAMES</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES ARMY WWI 218033031</b>			
16. SOCIAL SECURITY NO. <b>218033031</b>				17. INFORMANT Address <b>MRS. PEARL RUMMERFIELD CATONSVILLE MD</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO (c) <b>PULMONARY EMPHYSEMA.</b>				INTERVAL BETWEEN ONSET AND DEATH <b>MINUTES</b> <b>5 YRS.</b> <b>20 YRS.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>AUG 16, 1965</b> to <b>FEB 17, 1966</b> , that I last saw the deceased alive on <b>FEB 13, 1966</b> , and that death occurred at <b>5 A M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>John N. Snyder M.D. 6348 FREDERICK RD. 2/12/66</b> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <b>JOHN N. SNYDER M.D. CATONSVILLE 28 MD</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2/21/66</b>		22c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>		22d. LOCATION (City, town, or county) (State) <b>BALTIMORE MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WILLRICH FUNERAL HOME DUNDALK</b>				24a. REC'D BY REGISTRAR <b>FEB 21 1966</b>		24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
02095						02042							
1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Parkville</i> c. LENGTH OF STAY IN 1b <i>MARYLAND</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>3134 Willoughby Road</i>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Balto.</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Baltimore # 34</i> d. STREET ADDRESS <i>3134 Willoughby Rd.</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <i>Jessie</i> Middle <i>L.</i> Last <i>Whiteman</i>			4. DATE OF DEATH Month <i>February</i> Day <i>27</i> Year <i>1966</i>			5. SEX <i>Female</i>			6. COLOR OR RACE <i>White</i>				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <i>May 17, 1888</i>			9. AGE (In years last birthday) <i>77</i>			IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>			11. BIRTHPLACE (County & State, or foreign country) <i>West Virginia</i>			12. CITIZEN OF WHAT COUNTRY? <i>USA</i>				
13. FATHER'S NAME <i>John Klepfel</i>						14. MOTHER'S MAIDEN NAME <i>Annie Bartlett</i>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>						16. SOCIAL SECURITY NO. <i>215-54-0954</i>			17. INFORMANT Address <i>Mr. Charles Whiteman Jr. (Same)</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic middle cerebral artery</i> DUE TO (b) <i>Cerebral arteriosclerosis</i> DUE TO (c) <i>Cerebral arteriosclerosis</i> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												INTERVAL BETWEEN ONSET AND DEATH <i>20 yrs</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <i>Oct 7</i> , 19 <i>67</i> , to <i>Feb</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>Feb. 27</i> 19 <i>66</i> , and that death occurred at <i>4:15 PM</i> , from the causes and on the date stated above.													
22a. SIGNATURE <i>S. Elliott Harris</i>						22b. DATE SIGNED <i>2/28/66</i>			22c. PHYSICIAN'S NAME (Type) <i>S. Elliott Harris, MD</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>						23b. DATE THEREOF <i>3/3/66</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Wooddale Mem. Pk.</i>				
24. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc. Balto. Md. 21214</i>						25a. REC'D BY REGISTRAR <i>Charles Judge</i>			25b. REGISTRAR'S SIGNATURE				



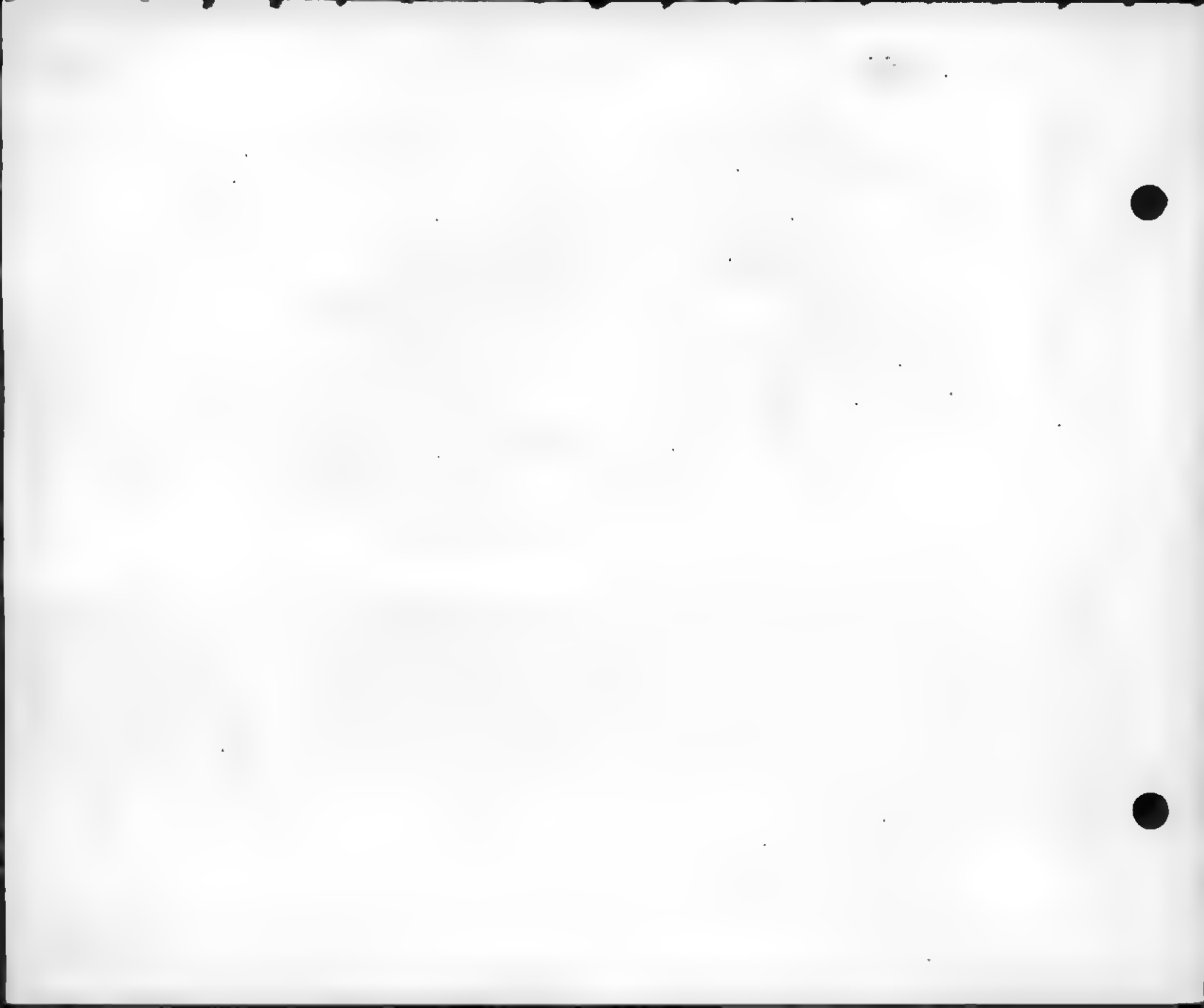
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>		c. LENGTH OF STAY IN 1b <b>3 1/2 mth, 2 dy</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore County</b>		d. STREET ADDRESS <b>SPRING GROVE STATE HOSPITAL 3416 FLANNERY LANE</b>	
3. NAME OF DECEASED (Type or print) First <b>OLGA</b> Middle <b>WHITTINGTON</b> Last <b>WHITTINGTON</b>		4. DATE OF DEATH Month <b>2</b> - Day <b>19</b> - Year <b>1966</b>		5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4-4-1891</b>	
9. AGE (In years last birthday) <b>74</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>AUSTRIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		9. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13. FATHER'S NAME <b>MARION WHITTINGTON</b>				14. MOTHER'S MAIDEN NAME <b>HERMINA GADDEL</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			
16. SOCIAL SECURITY NO. <b>213-01-3930</b>				17. INFIRMANT Address <b>SPRING GROVE STATE HOSPITAL</b>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HEART FAILURE, Congestion</b> DUE TO (b) <b>ARTERIOSCLEROTIC Cardiovascular Disease</b> DUE TO (c) <b>Cerebral Vascular accident</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from <b>7-17-1962</b> to <b>2-19-1966</b> that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred at <b>12 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Mehdi L. Yeganeh</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22b. DATE SIGNED <b>Feb. 19, 1966</b>			
22c. PHYSICIAN'S NAME (Type) <b>MEHDI L. YEGANEH</b>				22d. ADDRESS <b>38 Maple Drive, Baltimore 28, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>2/22/66</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Oaklawn</b>			
23d. LOCATION (City, town or county) (State) <b>Balto. Md.</b>				24. FUNERAL DIRECTOR <b>John L. ...</b>				25a. REC'D BY REGISTRAR <b>FEB 23 1966</b>			
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>											



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02097 CERTIFICATE OF DEATH 02044											
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>				c. LENGTH OF STAY IN 1b <b>11 mos.</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Rosewood State Hospital</b>						d. STREET ADDRESS <b>2835 Raynor Avenue</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Vanessa Harriett WILLIS</b>			First Middle Last			4. DATE OF DEATH <b>2 3 19 66</b>			Month Day Year		
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12/30/64</b>		9. AGE (in years last birthday) <b>1</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>dependent</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Charles Lee Willis</b>						14. MOTHER'S MAIDEN NAME <b>Gladys Geraldine Christian</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Rosewood Records, Owings Mills, Maryland</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Foreign body in lung aspirated</b> <b>7531</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Epilepsy</b> DUE TO (c) <b>Multiple congenital anomalies of brain</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
2Dc. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		2Df. (City or town) (County) (State)			
21. I certify that <del>the</del> (this hospital) attended the deceased from <b>3/2</b> , 19 <b>65</b> , to <b>2/3</b> , 19 <b>66</b> , that <del>he</del> (we) last saw the deceased alive on <b>2/3</b> , 19 <b>66</b> , and that death occurred at <b>1:00 PM</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Harry G. Butler</b>						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>2/4/66</b>			
22c. PHYSICIAN'S NAME (Type) <b>Harry G. Butler, M.D.</b>						22d. ADDRESS <b>Rosewood Lane, Owings Mills, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>		23b. DATE THEREOF <b>2/9/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Natl C.</b>				23d. LOCATION (City, town or county) (State) <b>Baltimore Md.</b>			
24. FUNERAL DIRECTOR <b>W. E. ...</b>						25a. REC'D BY REGISTRAR <b>Feb 10 1966</b>		25b. REGISTRAR'S SIGNATURE <b>...</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02098

## CERTIFICATE OF DEATH

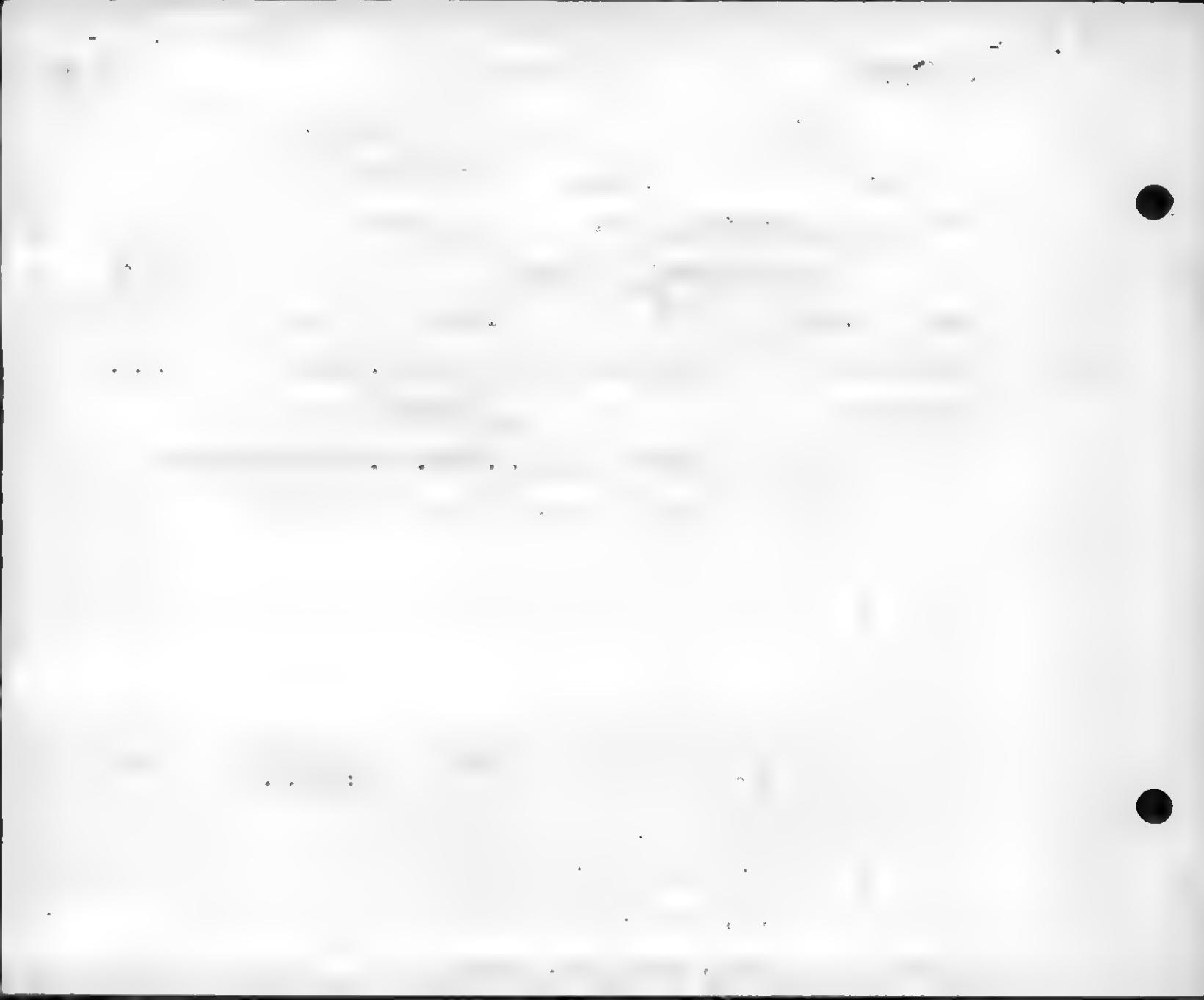
02045

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>+</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c LENGTH OF STAY IN 'b <b>11 Days</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>William Howard</b> Middle <b>Wood</b> Last		4 DATE OF DEATH Month <b>2</b> Day <b>25</b> Year <b>19 66</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>10/13/96</b>
9 AGE (in years last birthday) <b>69</b>		10 IF UNDER 1 YEAR Months Days	11 IF UNDER 24 HRS Hours Min.
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>	11 BIRTHPLACE (County & State or foreign country) <b>Oraville, Maryland</b>
12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>William Wood</b>	
14. MOTHER'S MAIDEN NAME <b>Unknown</b>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW I</b>	
16 SOCIAL SECURITY NO <b>578 09 53 14</b>		17 INFORMANT Address <b>V.A. Hosp. Ft. Howard, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY FAILURE</b> DUE TO (b) <b>BRONCHOPNEUMONIA</b> DUE TO (c) <b>CARCINOMA OF PROSTATE</b>			INTERVAL BETWEEN ONSET AND DEATH HOURS DAYS MONTHS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>2/14</b> , 19 <b>66</b> , to <b>2/25</b> , 19 <b>66</b> that (I) (we) last saw the deceased alive on <b>2/25</b> , 19 <b>66</b> , and that death occurred at <b>9:33 P.M.</b> from causes and on the date stated above.			
22a SIGNATURE <b>William B. Kingree M.D.</b>		22b DATE SIGNED <b>2 26 66</b>	
22c. PHYSICIAN'S NAME (Type) <b>WILLIAM B. KINGREE, M.D.</b>		22d ADDRESS <b>VET. ADM. HOSP., FT. HOWARD, MARYLAND</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b DATE THEREOF <b>FEB. 28, 1966</b>	23c NAME OF CEMETERY OR CREMATORY <b>ST. JOSEPHS CEMETERY</b>	23d LOCATION (City or Town) (County) (State) <b>MORGANZA, MARYLAND</b>
24 FUNERAL DIRECTOR ADDRESS <b>Mattingley Funeral Home, Leonardtown, Maryland</b>		25a REC'D BY REGISTRAR <b>R 1 1966</b>	25b REGISTRAR'S SIGNATURE <b>g Charles Judge</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

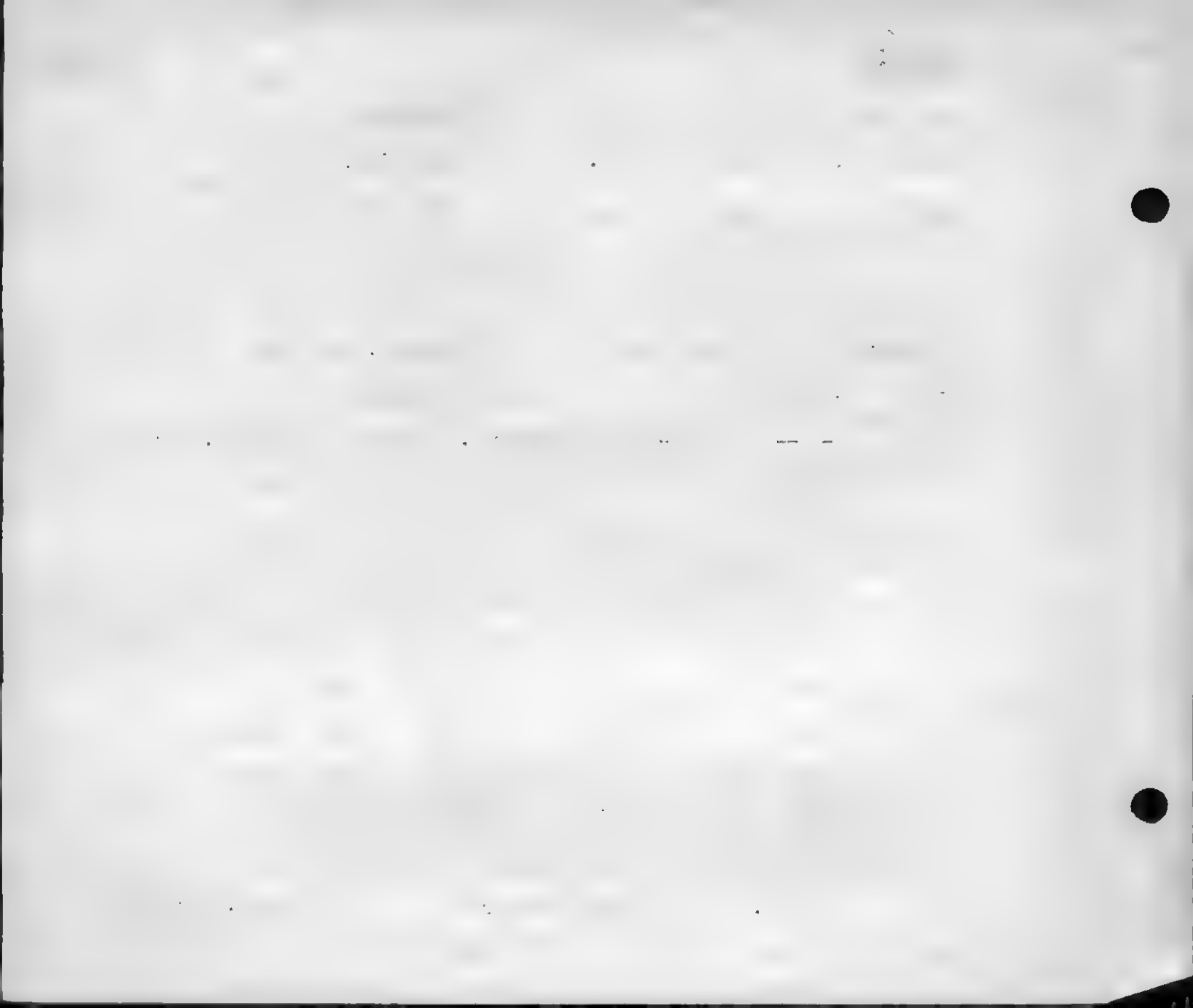
## CERTIFICATE OF DEATH

02099

02046

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Kingsville, Maryland</u> <span style="float: right;">c. LENGTH OF STAY IN 1b</span> <u>5 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Mohr Road</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Baltimore</u></span> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Kingsville</u> <span style="float: right;">d. STREET ADDRESS</span> <u>Mohr Road</u>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Rose</u> <span style="float: right;">First</span> <u>Wooden</u> <span style="float: right;">Middle</span> <span style="float: right;">Last</span>		<b>4. DATE OF DEATH</b> Month <u>Feb</u> Day <u>22</u> Year <u>1966</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>5. SEX</b> <u>F</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>Nov. 24 1892</u> <span style="float: right;">9. AGE (in years last birthday) <u>73</u> yrs.</span>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>At Home</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Baltimore, Maryland</u>			
<b>13. FATHER'S NAME</b> <u>PATRICK O'Conner</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>MARY unknown</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give year or dates of service) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b> <u>220-44-9349</u>		<b>17. INFORMANT</b> <u>Elmer B. Kurrle</u> <span style="float: right;">Address <u>Kingsville, Maryland</u></span>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>4201</u> <span style="float: right;">DUE TO</span> Conditions, if any, which gave rise to immediate cause (b) <u>Arterio Sclerosis</u> (a), stating the underlying cause last. <span style="float: right;">DUE TO</span> <span style="float: right;">(c)</span>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes</u>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <span style="float: right;">p.m.</span> <span style="float: right;">19</span>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Sept. 1959</u> <b>to</b> <u>Feb. 1966</u> <b>that (I) (we) last saw the deceased alive on</b> <u>Feb. 14 1966</u> <b>and that death occurred at</b> <u>5:15 PM</u> <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>William A. Tyson</u> <span style="float: right;">M.D.</span>				<b>22b. DATE SIGNED</b> <u>2-22-66</u>			
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>William A. Tyson</u>				<b>22d. ADDRESS</b> <u>Kingsville</u>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>Feb 25, 1966</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Parkwood Cemetery</u>			
<b>23d. LOCATION (City, town or county)</b> <u>Baltimore, Maryland</u>		<b>(State)</b>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>The Dippel Brothers Inc</u> <span style="float: right;">ADDRESS <u>7110 Belair Road 21206</u></span>				<b>25a. REC'D BY REGISTRAR</b> <u>FEB 25 1966</u>			
<b>25b. REGISTRAR'S SIGNATURE</b> <u>[Signature]</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



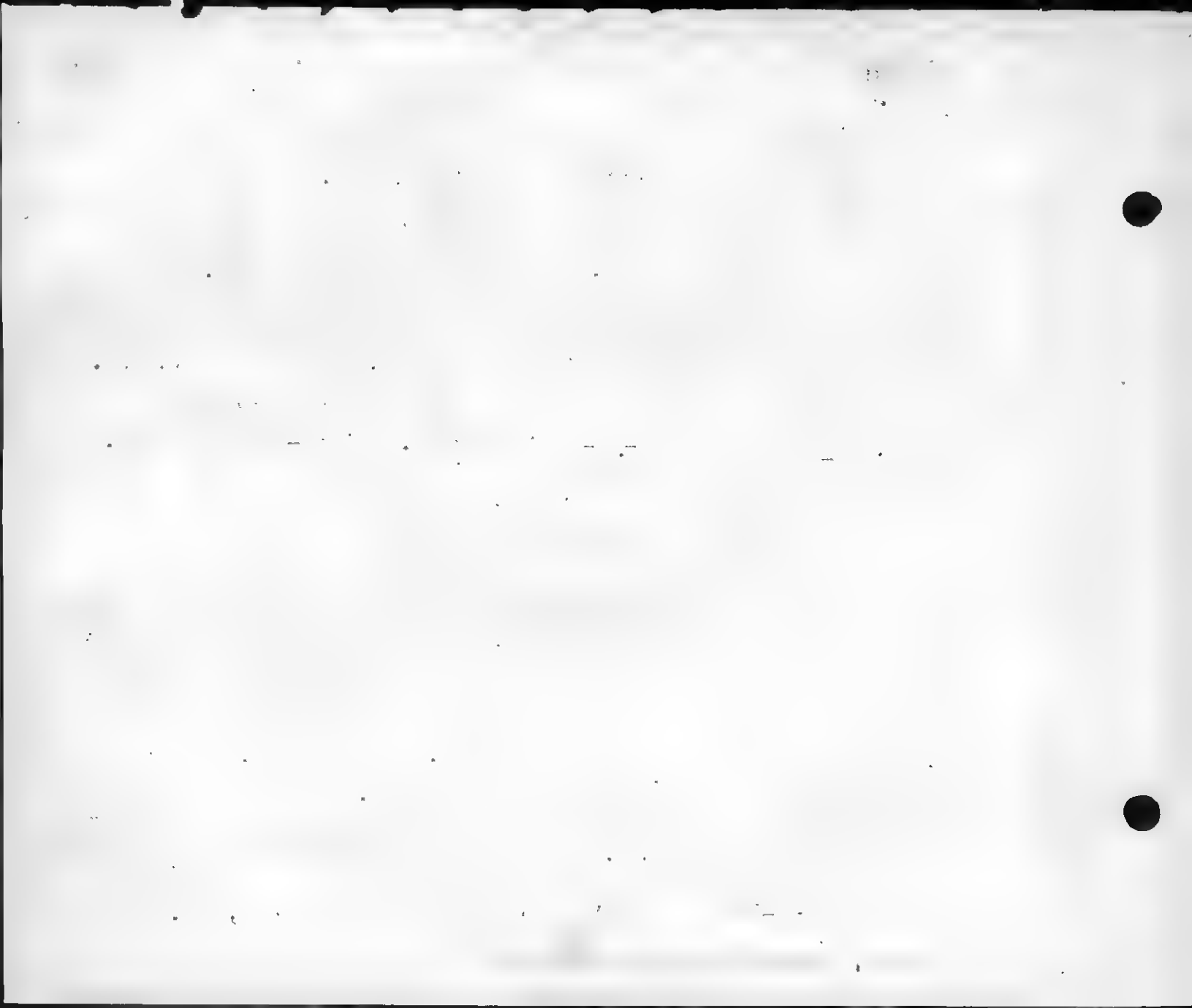
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and at any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>5yr 10mth 29dys</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince George's</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Clinton, Md.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>						d. STREET ADDRESS <b>9 Manor Road</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Howard C. Wright</b>			4. DATE OF DEATH <b>Feb. 27 19 66</b>			5. SEX <b>male</b>			6. COLOR OR RACE <b>white</b>		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			8. DATE OF BIRTH <b>Sept. 27, 1886</b>			9. AGE (in years last birthday) <b>79 yrs.</b>			10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Interstate Commerce</b>			11. BIRTHPLACE (County & State, or foreign country) <b>Penna.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>unknown</b>			14. MOTHER'S MAIDEN NAME <b>unknown Ella Clifford</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>unknown Yes - WW I</b>			16. SOCIAL SECURITY NO. <b>220-44-4740</b>		
17. INFORMANT <b>Clara T. Wright - See item #2.</b>			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal pneumonia</b> DUE TO (b) <b>Congestive heart failure</b> DUE TO (c) <b>Arteriosclerotic heart disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Sept. 28, 1969</b> to <b>Feb. 27, 1966</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Feb. 27, 1966</b> , and that death occurred at <b>11:55 a.m.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Imre Kopits, M. D.</b>			22b. DATE SIGNED <b>2-28-66</b>			22c. PHYSICIAN'S NAME (Type) <b>Imre Kopits, M. D.</b>			22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>3-4-1966</b>			23c. NAME OF CEMETERY OR CREMATORY <b>XXXX Cedar Hill Cemetery, Md.</b>			23d. LOCATION (City, town or county) (State)		
24. FUNERAL DIRECTOR <b>JOSEPH GAWLER'S SONS/INC. WASH, D.C.</b>			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			DATE		

MEDICAL CERTIFICATION



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02048

FOR STATE HEALTH DEPT.

02101

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore Essex</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>842 Brunswick Road</b>		d. STREET ADDRESS <b>3 Clipper Rd. 842 Brunswick Road</b>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>Paylor</b> Last <b>WRIGHT</b>		4. DATE OF DEATH Month <b>February</b> Day <b>27</b> Year <b>19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/2/05</b>
9. AGE (In years last birthday) <b>60 yrs</b>		IF UNDER 1 YEAR Months <b>60</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Self Employed</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Ill.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Carroll Wright</b>		14. MOTHER'S MAIDEN NAME <b>Marion</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <b>Glenn Wright</b> Address <b>918 Ashbridge Drive</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Gunshot wound of head</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Shot self in head</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Shot self in head</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>2 27 19 66</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Baltimore, Balto., Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Russell S. Fisher</b> M.D. EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b>		22. DATE SIGNED <b>2-28-66</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/2/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Morelands</b>		23d. LOCATION (City or town) (County) (State) <b>Balto. Md.</b>	
24. FUNERAL DIRECTOR <b>Connolly Sons 300 Nace Ave. Balto.</b>		25a. REC'D BY REGISTRAR <b>MAR 3 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02049

<b>1. PLACE OF DEATH</b> a. COUNTY <u>BALTIMORE</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RURAL - ESSEX</u> <span style="float: right;">18 YRS</span> c. LENGTH OF STAY IN TB d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>409 WORTON ROAD</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> <span style="float: right;">b. COUNTY <u>BALTIMORE</u></span> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RURAL - ESSEX</u> d. STREET ADDRESS <u>409 WORTON ROAD</u>									
<b>3. NAME OF DECEASED</b> (Type or print) <u>ROBERT A. WRIGHT</u> First Middle Last				<b>4. DATE OF DEATH</b> <u>FEBRUARY 18 1966</u> Month Day Year									
<b>5. SEX</b> <u>M</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>NOV. 19 1894</u>		<b>9. AGE</b> (In years last birthday) <u>71</u> yrs.		<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>RETIRED PRINTER</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>B &amp; O. R.R.</u>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>BALTIMORE MD.</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<b>13. FATHER'S NAME</b> <u>late FRANK WRIGHT</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>late ANNA</u>							
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				<b>16. SOCIAL SECURITY NO.</b>				<b>17. INFORMANT</b> <u>Mrs RUTH WRIGHT 409 WORTON RD 21221</u> Address					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1561</u> DUE TO <u>Cancer of the liver with metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Uremia secondary to above.</u> DUE TO (c) <u>1 year</u> < few weeks													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>no</u>													
<b>20e. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>									
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>—</u> 19 <u>66</u> p.m.				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)					
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Jan 18, 1966</u> <b>to</b> <u>Feb 18, 1966</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>Feb 17, 1966</u> , <b>and that death occurred at</b> <u>11 AM</u> , <b>from the causes and on the date stated above.</b>													
<b>22a. SIGNATURE</b> <u>Irving R. Beck</u> M.D.						<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>			<b>22b. DATE SIGNED</b>				
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>IRVING R. BECK M.D.</u>						<b>22d. ADDRESS</b> <u>901 FUSELAGE AV BALTIMORE 20 MD.</u>							
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>				<b>23b. DATE THEREOF</b> <u>FEB. 23 1966</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>LODGE PARK</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>BALTIMORE MARYLAND</u>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Samuel H. Wright</u> ADDRESS <u>4101 EDWARDS AVE</u>						<b>25a. REC'D BY REGISTRAR</b> <u>FEB 21 1966</u> DATE			<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00000

00150

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

02108

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02051

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Upper Marlboro, Maryland</b>	
c. LENGTH OF STAY IN 1b <b>4yr6mth16dys</b>		d. STREET ADDRESS <b>none</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Gladys- Pyles Wyvill</b>		4. DATE OF DEATH <b>February 4 19 66</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. <input checked="" type="checkbox"/> MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>April 12, 1903</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>62</b> yrs.
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>unknown: George Washington Pyles</b>		14. MOTHER'S MAIDEN NAME <b>unknown: Clara Smith</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral pyelonephritis</b> <b>6000</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>July 18, 19 61</b> to <b>Feb. 4, 19 66</b> , that <b>10</b> (we) last saw the deceased alive on <b>Feb. 4, 19 66</b> , and that death occurred at <b>7:30</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Stella Wachsler</b>		22b. DATE SIGNED <b>2-4-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Stella Wachsler, M. D.</b>		22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Feb. 7-1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Carmel Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Upper Marlboro, Maryland</b>
24. FUNERAL DIRECTOR <b>Sammons Bros.</b>		25a. REC'D BY REGISTRAR <b>DATE 7 1966</b>	
ADDRESS <b>Sammons Bros. 1661-Good Hope Rd SE Wash DC</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

00100